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WISCONSIN MEDICAL JOURNAL

JANUARY 1982

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- MEB new policy—CME requirements [news you can use—page 112]
- Membership facts [page 12]
- Membership Directory 1981-82 [page 13]

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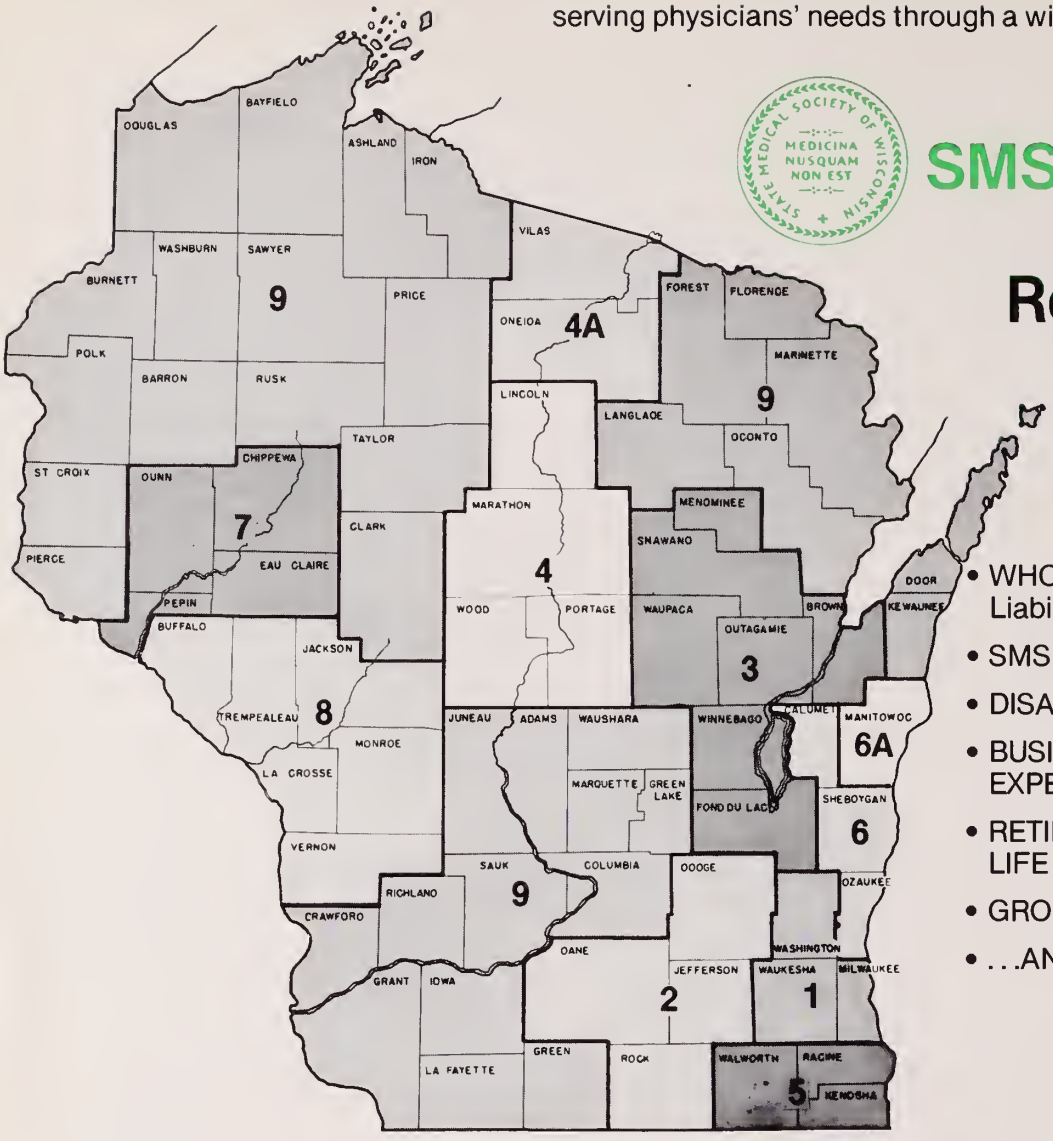

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WISCONSIN MEDICAL JOURNAL (ISSN 0043-6542) is the official publication of the State Medical Society of Wisconsin, devoted to the interests of the medical profession and health care in Wisconsin. Its affairs are handled by the Editorial Board, subject to policy direction of the Board. The Managing Editor is responsible for the production, business operation, and coordination of contents as well as the final responsibility of the entire publication. The Editorial Director is responsible for Editorials. In Editorials, official positions of the Society will be expressly identified as such; all others are views of the writer and not necessarily those of the Society. Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed in the pages of the Journal. Indexed in "Index Medicus," "Hospital Literature Index," and "Cambridge Scientific Abstracts." Contents page included in "Current Contents/Clinical Practice."

Editorials WAYNE J BOULANGER, MD, *Editorial Director*

Official positions of the Society will be expressly identified as such; all others are views of the writer and not necessarily those of the Society.

Medicaid audits

ABOUT SIX MONTHS ago the State Department of Health and Social Services started a series of 25 audits each among physicians, dentists, and pharmacists. Those audited were selected on the basis of some known or perceived marked variation from usual service or billing practices.

The purpose of those audits was fully understood and accepted by the State Medical Society. Audits under such circumstances are wise and in the public interest. They should be expected by the professions; indeed, the Department would be viewed as lax if it ignored warning signs of potential fraud or abuse. The State Medical Society supported what looked to be a responsible effort in this direction through the proposed Medicaid audits.

Unfortunately, the first series of audits appeared to start from the premise that those being audited were known "crooks"—the audit was a mere formality to prove it. The Society and other professional organizations made allegations, ultimately conceded in part by the Department, that certain personal and business rights of providers and recipients may have been violated. Corrections were made.

Since then, Society President Motzel and Secretary Thayer arranged a meeting with DHSS Medicaid Director Preizler and the contracted auditor J L Trainor of JLT, Inc. It was agreed that a repetition of such confrontations must be avoided. It was agreed that ***before*** the next series of audits is launched, there will be discussions of how the audits will be conducted, the atmosphere of the audit, and the manner and means by which information of the rights of all parties are to be respected. Moreover, the overall results of the audits should be disclosed without needless damage to individuals or to institutions.

To engage in such preliminary informational meetings does not compromise the public interest. Quite the contrary. Properly implemented it can build rather than destroy confidence in the Department by all who have an interest in assuring quality care and cost-efficient service for Title 19 recipients.

The Medicaid operation, in the words of the administrator of the Division of Health in DHSS, can "no longer afford to be on an adversarial track with physicians."

The next Medicaid audit series is a good place for a re-start of that philosophy. —ERT

Double-jointed pot plan

THE LEGISLATURE'S questionable practice of doing something for a legislator because he/she has only one major interest in a session raises some serious questions of public policy. A case in point is Representative David Clarenbach's bill (AB 697) to set up a totally duplicative program to provide marijuana in capsule or cigarette form to relieve patients suffering the side-effects of glaucoma or radiologic or chemotherapy treatment.

For nearly a year Wisconsin physicians and patients have had precisely the same program available to them through the state's Controlled Substances Board. The Board is composed of the Attorney General, secretaries of the Departments of Agriculture, Trade and Consumer Protection and the Department of Health and Social Services, plus a representative of the Pharmacy Examining Board, a pharmacist, and a physician.

The program has already served more than 300 cancer patients with marijuana in THC capsule form. Sixty physicians and 11 hospitals are approved for the program. Others can be if they wish to meet the simple eligibility requirements.

So far, no physician has requested smokable marijuana for a patient. If one did so, the Board would obtain federal release of marijuana in that form. Nothing in Clarenbach's bill makes it easier to get smokable marijuana; only the feds can release it and only upon application of the exact type used by the present Controlled Substances Board.

Representative Clarenbach and supporters of his bill unfortunately appear to have some kind of personal vendetta going with the members of the Controlled Substances Board. No other explanation makes sense. The State Medical Society sees a second program as totally unnecessary.

AB 697 is either disjointed (lacking coherence) or double-jointed (excessively free). Crudely put, why have two joints when one will do? —ERT

Suing students

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The disadvantages are almost equally well known; but ***they can be avoided!*** *Most problems are the result of* ***inexperience, insufficient planning, poor choices, inadequate support and training of personnel, and inappropriate equipment.***

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school. A university refused to readmit her so she filed suit for violation of the Rehabilitation Act.

Another medical school dismissed some students on the basis of their academic records, class standings, and two failures on the National Board examinations. The former students contended that their dismissals constituted a violation of due process. This went through an Appellate Court where it was found that the lower court was correct in finding for the medical school.

In another case a 39-year-old woman who did not have a good undergraduate grade-point average, and her scores on the NCAT placed her in the bottom half of the applicants, was denied admission to two medical schools and sued on the basis of sexual discrimination. This case also went through two courts before being dismissed.

In a reversed situation a medical school professor sued four of his black students because they had filed a complaint against him. This also went to a state Supreme Court, and a judgment was entered for the students.

It is true we live in a litigious era, but can you imagine the reactions of some of the peppery medical school deans we knew a generation ago if anyone had brought suit against their medical schools? —VSF

When "it's Miller time" all the time

"I AM A RECOVERING alcoholic. I'm not proud of it. I'm not ashamed of it, either. That's what I am. I have a progressive, fatal disease. I brought it on myself. Now it's part of my life. . .forever."

With those words, Dennis Lick, former UW football star now playing pro ball with the Chicago Bears, began his humble but eloquent message to 650 teenagers from 54 high schools attending the State Medical Society's 19th annual Work Week of Health at Platteville. His words riveted the attention of his youthful audience. They found out what it's really like when "it's Miller time" all the time.

The numbers associated with alcohol costs are staggering. The deaths related to its use are terrifying. When you've said that, you have not, as the song goes, said it all. The personal suffering, the family tragedies, the enduring pain of never-quite-achieved cure are unimaginable. And all, as Dennis Lick said, so unnecessary.

Important postscript: Congratulations to the Auxiliary who, with the State Medical Society, has had the courage and good sense to openly address this issue with Wisconsin's teenagers. Moreover, the program was a tribute to one of Wisconsin's medical

pioneers, Wilson Cunningham, MD, of Platteville. His life inspired bequests to the CES Foundation which in turn made possible this program and many others like it. Give that man a gold medal. —ERT

No limit?

IS THERE NO LIMIT to the number of groups, superimposed on governmental agencies at all levels, that seems determined to erode or impinge on the freedom of physicians?

Hospital boards and executive directors or hospital administrators have come up with a new one. A proposed change in bylaws at one hospital would give the administrator virtually unrestricted power to exclude a qualified professional from the staff because of the administrator's perception that the individual lacks the elusive and really undefinable characteristic of compatibility. That word was incompatibility, not impairment. It is true that not all physicians have sunny dispositions, and some of them can become quite abrasive in relationships with their colleagues. But for a hospital administrator to prevent staff affiliation of a physician because of the former's perception that the physician lacks compatibility is of doubtful wisdom or legality.

In the interests of its professional integrity and independence, no medical staff should tolerate the centralization of this kind of authority in any hospital administrator. — VSF

Partners

FOR ALMOST twenty years Wisconsin and Nicaragua have been sister-states. Wisconsin has been active in promoting improvement in such diverse fields as medicine, education, agriculture, transportation, and communication. The medical aspect has been an important one through the years. Wisconsin has contributed generously, especially after the devastating earthquake in Managua.

A medical survey team from Wisconsin has met with the "moderates" in the Nicaragua Ministry of Health. This was to determine manpower shortages in particular medical specialties where needs have reached a crisis and to recruit physicians. The physicians are needed to provide medical and surgical care, to lecture in the medical school, and to conduct seminars for local physicians.

There are two ways Wisconsin physicians can help. One is to volunteer for two or three weeks service in Nicaragua. (I have done this three times in the past and found it to be a rewarding and challenging experience.) The other is to sponsor two

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Fascinating physiology: cellulite

AN OLD AD FOR a 5¢ cigar proclaimed that "spit is a horrid word, but it's worse on the end of your cigar." But now we have "cellulite"-body wastes that accumulate beneath the skin in concentrated areas, such as thighs and buttocks.

Just how this selective disposal of body wastes comes about is not explained by the advertising from the figure-contouring and facial salons. However, they do state that "cellulite is not a weight problem, it's a circulation problem." Thus, by speeding up circulation in those areas the cellulite is flushed out. If you have problems other than the accumulated wastes in your thighs and buttocks, there are also facial treatments available. A European mask is used to "draw out impurities and restore elasticity to the skin for youthful appearance."

So, if you agree that "ripples look great in the ocean, but not on your body," get the cellulite out.

—VSF■

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FWT-24 C-E-L

Letters

The Editors would like to encourage physicians to contribute to the LETTERS section where they can ventilate their frustrations as well as opinions. This feature is intended to be lively and spirited as well as informative and educational. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address correspondence to: The Editor, Wisconsin Medical Journal, Box 1109, Madison, Wis 53701.

Partners

TO THE EDITOR: For the past 17 years Nicaragua has been Wisconsin's Partner state through the Partners of the Americas program. The Central American nation is still recovering from the revolution of July 1979 and the need for medical services and supplies and equipment has become desperate. More than half of the practicing physicians have fled the country for economic or political reasons.

The Wisconsin/Nicaragua Partners, a private, nonpolitical, people-to-people organization, is asking for help in two ways: (1) sponsorship of young Nicaraguan medical students [two per community, including gratis living with families here] for a hospital/clinic/doctor's office training experience for two or three months [anytime from December 1981 through February 1982]; and (2) two to three weeks of voluntary service by Wisconsin physicians in Nicaragua during 1982 [round trip travel and modest per diem provided]. Ability to speak some Spanish and prior experience in a Third World country preferred, but not essential. Please contact Partners, 1856 Van Hise Hall, 1220 Linden Dr, Madison, Wis 53706, or call 608/263-3360 regarding either program.

Wisconsin-Nicaragua Partners
Madison, Wisconsin

Medical Genetics Board

TO THE EDITOR: This is to inform you that the American Board of Medical Genetics, Inc was incorporated in 1980 at the request of the American Society of Human Genetics to provide accreditation of training programs and certification of individuals who provide Medical Genetics Services.

Thus the first examination in Medical Genetics was offered and written by eligible candidates at approximately nine centers in the United States, on Dec 9, 1981.

It was in two parts: the first was a general examination in basic genetics taken by all the candidates; the second consisted of specialty examinations allowing certification in the following areas: clinical genetics (MDs, DDSs, etc), PhD medical genetics (for PhDs), clinical biochemical genetics, clinical cytogenetics, genetic counseling (master's degrees in genetics).

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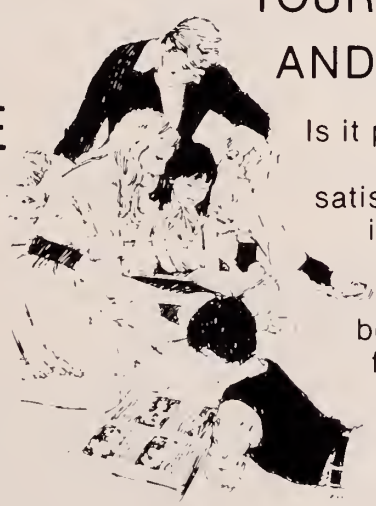

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MEMBERSHIP FACTS

ARE YOU A MEMBER of the State Medical Society of Wisconsin, or do you know someone who isn't? Whether you're just starting medical school, maintain a full-time practice, or are retired, SMS has a membership classification to fit your individual needs. Furthermore, in light of a recent change in membership policy, physicians may join their county and state societies and the AMA or just their county and state societies; however, AMA membership is encouraged. Dues for regular membership are $410 for SMS, $285 for AMA, and county society dues vary. A more detailed listing of SMS membership classifications and their corresponding dues follows:

State Medical Society of Wisconsin

DESCRIPTION OF DUES CLASSIFICATION CODES

Regular: Member in active practice. Some are regular members that have reduced SMS and/or AMA dues because they are new practitioners (first year or two out of residency).

Resident: Physician who at January 1 of dues year is in an approved training program as a hospital resident or research fellow who is licensed to practice medicine and surgery in Wisconsin.

Military Service: Members who are serving in the U.S. armed forces (generally not to exceed five years).

Associate: Member whose dues are waived because of illness or financial hardship. This classification is temporary and is reviewed on an annual basis.

Life: Member who has held membership in a state medical society for 50 years or is a Past President of the State Medical Society of Wisconsin.

Honorary: Member who was named by the Board of Directors in recognition of long and distinguished service to the cause of medicine.

Retired: Member who has completely retired from practice (works less than 240 hours per year). All dues are waived unless county society indicates they wish to charge county dues.

Part-time Practice: Physician, regardless of age, who practices 1,000 hours or less during the calendar year but does not qualify for retired membership.

Over Age 70: Member in active practice who is over 70 years of age.

Candidate: Member attending a medical school in Wisconsin or fulfilling a postgraduate obligation prior to eligibility for licensure.

Scientific Fellow: Member who is engaged in teaching one or more of the basic sciences at an accredited college or university, and not holding the degree of Doctor of Medicine or Osteopathy.

Emeritus: Retired members who have chosen not to renew their license.

1982 DUES AMOUNTS FOR THESE CLASSIFICATIONS

	SMS	AMA	COUNTY
Regular	$410	$285	Normal County Dues
Resident	41	35	Varies
Military Service	-0-	285 or 35	-0-
Associate	-0-	-0-	-0-
Life	-0-	-0-	-0-
Honorary	-0-	-0-	-0-
Retired	-0-	-0- *	-0-
Part-time Practice	205	285 *	Normal County Dues
Over Age 70	205	-0- *	Normal County Dues
Scientific Fellow	-0-	-0-	
Emeritus	-0-	-0-	
Candidate—			
Freshman Year Medical Student	-0-	15	Varies
Sophomore and Succeeding Medical Student Years	10	15	Varies
Postgraduate—One	10	35	Varies

*Due to recent policy changes by the AMA, future exemptions from AMA dues will be given to those physicians who are over 70 years of age *and* are retired from practice or practice 1000 hours or less a year.

Membership Department note: Physicians listed in this directory are members of their County Medical Society and the State Medical Society of Wisconsin in good standing as of December 31, 1981. To the many who have paid 1982 dues—thank you! Some members are dues exempt thus owing no County or State Society dues. Members still owing some or all of 1982 dues are encouraged to retain their membership by paying the amount due as soon as possible. Remember, the Bylaws provide that any member who has not paid dues *in full by May 15* must be removed from the membership rolls. This also carries with it forfeiture of all membership benefits. Your continued support is needed and encouraged.

STATE MEDICAL SOCIETY OF WISCONSIN

1981-1982

Membership Directory

as of December 31, 1981

Listed by county medical society in alphabetical order.

This directory includes member's name, address, telephone number, and primary and secondary specialties. Every effort was made to provide accurate listing. Members received a postcard for return to the Journal office for verification of information provided by the Membership Department. Telephone numbers are included when provided by members.

In the event of inaccuracies members are asked to contact the Journal office for followup correction.

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State Medical Society of Wisconsin
Box 1109, Madison, Wisconsin 53701

Key to CITIES in COUNTY MEDICAL SOCIETIES

City — *County Medical Society / ies*

Adams—Adams
Adell—Sheboygan
Algoma—Door/Kewaunee
Alma—Trempealeau/Jackson/Buffalo
Altoona—Eau Claire/Dunn/Pepin
Amery—Polk
Antigo—Langlade
Appleton—Outagamie, Winnebago
Arcadia—Trempealeau/Jackson/Buffalo
Arkansaw—Pierce/St Croix
Ashland—Ashland/Bayfield/Iron

Baldwin—Pierce/St Croix
Baraboo—Sauk
Barron—Barron/Washburn/Burnett
Bayside—Milwaukee
Beaver Dam—Dodge, Jefferson
Belgium—Milwaukee, Ozaukee
Belleville—Dane
Beloit—Rock
Berlin—Green Lake/Waushara
Black Earth—Dane
Black River Falls—Trempealeau/Jackson/Buffalo
Blair—Trempealeau/Jackson/Buffalo
Bloomer—Chippewa
Bonduel—Shawano
Boscobel—Grant
Brillion—Calumet
Brookfield—Milwaukee, Waukesha
Brooklyn—Green, Dane
Brownsville—Fond du Lac
Bruce—Rusk
Burlington—Kenosha, Milwaukee, Racine
Butte Des Morts—Winnebago

Cadott—Chippewa
Caledonia—Racine
Cambridge—Jefferson
Campbellsport—Fond du Lac
Casco—Door/Kewaunee
Cassville—Grant
Cedarburg—Ozaukee
Cedar Grove—Jefferson
Chetek—Barron/Washburn/Burnett
Chilton—Calumet
Chippewa Falls—Chippewa, Eau Claire/Dunn/Pepin
Clam Lake—Dane
Clear Lake—Polk
Clintonville—Waupaca
Colby—Clark
Columbus—Columbia/Marquette/Adams, Dodge, Jefferson
Cornell—Chippewa
Crandon—Forest
Crivitz—Marinette/Florence
Cross Plains—Dane
Cuba City—Grant
Cudahy—Milwaukee
Cumberland—Barron/Washburn/Burnett

DeForest—Dane
Delafield—Milwaukee, Waukesha
Delavan—Walworth
Denmark—Brown
DePere—Brown, Oconto
Dodgeville—Iowa
Dousman—Waukesha
Durand—Eau Claire/Dunn/Pepin, Trempealeau/Buffalo/Jackson

Eagle—Waukesha, Milwaukee
Eagle River—Oneida/Vilas
East Ellsworth—Pierce/St Croix
East Troy—Walworth, Milwaukee
Eau Claire—Eau Claire/Dunn/Pepin, Chippewa
Edgerton—Rock
Elcho—Langlade
Eleva—Trempealeau/Buffalo/Jackson, Eau Claire/Dunn/Pepin
Elkhart Lake—Sheboygan
Elkhorn—Walworth
Ellsworth—Pierce/St Croix
Elm Grove—Milwaukee, Waukesha
Elmwood—Pierce/St Croix
Elroy—Juneau
Evansville—Rock

Fall Creek—Eau Claire/Dunn/Pepin
Fennimore—Grant
Fond du Lac—Fond du Lac
Fontana—Walworth
Fort Atkinson—Jefferson
Fox Point—Milwaukee
Franklin—Milwaukee
Franksville—Racine, Sauk
Frederic—Polk
Friendship—Columbia/Marquette/Adams

Galesville—Trempealeau/Jackson/Buffalo
Germantown—Waukesha
Gillett—Oconto
Glendale—Milwaukee
Glenfield—Milwaukee
Glenwood City—Pierce/St Croix
Grafton—Ozaukee, Milwaukee
Grantsburg—Burnett
Green Bay—Brown
Greendale—Milwaukee
Greenfield—Marathon, Milwaukee
Green Lake—Green Lake, Winnebago
Greenwood—Clark
Greshem—Shawano

Hales Corners—Kenosha, Milwaukee
Hartford—Washington
Hartland—Milwaukee, Waukesha
Hayward—Sawyer
Hazel Green—Grant
Hewitt—Wood
Hilbert—Calumet
Hillsboro—Vernon
Hollandale—Iowa
Horicon—Dodge
Hortonville—Outagamie
Hubertus—Washington, Milwaukee, Waukesha
Hudson—Pierce/St Croix
Hurley—Ashland/Bayfield/Iron

Iola—Waupaca

Jackson—Washington
Janesville—Rock
Jefferson—Jefferson
Juneau—Dodge

Kaukauna—Outagamie
Kenosha—Kenosha, Racine
Kewaskum—Washington
Kewaunee—Door/Kewaunee
Kiel—Sheboygan
Kimberly—Outagamie
King—Waupaca
Kohler—Sheboygan

La Crosse—La Crosse
Ladysmith—Rusk
Lake Geneva—Walworth
Lake Mills—Jefferson
Lake Tomahawk—Oneida/Vilas
Lancaster—Grant
Land O'Lakes—Oneida/Vilas
Laona—Forest
Little Chute—Outagamie
Lodi—Columbia/Marquette/Adams
Loyal—Clark
Luxemburg—Door/Kewaunee/Brown

Madison—Dane
Manawa—Waupaca
Manitowoc—Manitowoc
Marathon—Marathon
Markesan—Dodge
Marinette—Marinette/Florence
Marshfield—Wood
Mauston—Juneau
Mayville—Dodge, Milwaukee
Mazomanie—Dane
Medford—Price/Taylor
Menasha—Outagamie, Winnebago
Menomonee Falls—Washington, Waukesha Milwaukee
Menomonie—Eau Claire/Dunn/Pepin
Mequon—Milwaukee, Ozaukee
Merrill—Lincoln
Middleton—Dane
Milton—Rock, Vernon
Milwaukee—Milwaukee, Ozaukee, Washington, Waukesha
Mineral Point—Iowa
Minocqua—Oneida/Vilas
Mishicot—Manitowoc
Mondovi—Trempealeau/Jackson/Buffalo
Monona—Dane
Monroe—Green
Montfort—Iowa
Monticello—Green
Montello—Columbia/Marquette/Adams
Mosinee—Marathon
Mt Calvary—Fond du Lac
Mt Horeb—Dane
Mukwonago—Milwaukee, Waukesha
Muscoda—Grant

Nashotah—Waukesha, Milwaukee
Neenah—Outagamie, Winnebago
Neillsville—Clark
Nekoosa—Wood

City *County Medical Society / ies*

New Berlin—Waukesha, Milwaukee
New Glarus—Green
New Holstein—Calumet
New Lisbon—Juneau
New London—Waupaca
New Richmond—Pierce/St Croix

Oconomowoc—Milwaukee, Waukesha
Oconto—Marinette/Florence, Oconto
Oconto Falls—Oconto
Omro—Winnebago
Onalaska—Dodge, LaCrosse
Oneida—Outagamie, Brown
Osseo—Trempealeau/Jackson/Buffalo, Eau Claire/Dunn/Pepin
Oostburg—Sheboygan, Milwaukee
Oregon—Dane
Orfordville—Rock
Osceola—Polk
Oshkosh—Winnebago
Owen—Clark
Oxford—Columbia/Marquette/Adams

Park Falls—Price/Taylor
Peshtigo—Marinette/Florence
Pewaukee—Waukesha, Milwaukee
Phelps—Oneida/Vilas
Phillips—Price/Taylor
Plain—Sauk
Platteville—Grant
Plum City—Pierce/St Croix
Plymouth—Sheboygan
Portage—Columbia/Marquette/Adams
Port Washington—Ozaukee
Poynette—Dane
Prairie du Chien—Crawford
Prairie du Sac—Sauk
Prescott—Pierce/St Croix
Pulaski—Brown

Racine—Racine, Kenosha, Milwaukee
Random Lake—Sheboygan

City *County Medical Society / ies*

Redgranite—Green Lake/Waushara
Reedsburg—Sauk
Rhinelander—Oneida/Vilas
Rice Lake—Barron/Washburn/Burnett
Richfield—Washington
Richland Center—Richland
Ripon—Fond du Lac, Winnebago
River Falls—Pierce/St Croix
River Hills—Milwaukee
Rosholt—Portage
Rothschild—Marathon

St Croix Falls—Polk
Shawano—Shawano
Sheboygan—Sheboygan
Sheboygan Falls—Sheboygan
Shell Lake—Barron/Washburn/Burnett
Shorewood—Milwaukee
South Milwaukee—Milwaukee
Sparta—Monroe
Spooner—Barron/Washburn/Burnett
Spring Green—Sauk
Spring Valley—Pierce/St Croix
Stanley—Chippewa
Stetsonville—Price/Taylor
Stevens Point—Portage
Stockbridge—Calumet
Stoughton—Jefferson, Dane
Sturgeon Bay—Door/Kewaunee
Sun Prairie—Dane, Dodge
Superior—Douglas
Sussex—Washington

Theresa—Dodge
Thiensville—Ozaukee, Milwaukee
Tomahawk—Lincoln
Three Lakes—Oneida/Vilas, Milwaukee
Tomah—Monroe
Two Rivers—Manitowoc
Turtle Lake—Barron/Washburn/Burnett, Polk

City *County Medical Society / ies*

Union Grove—Racine

Valders—Manitowoc
Verona—Dane
Viroqua—Vernon

Walworth—Walworth
Washburn—Ashland/Bayfield/Iron
Waterford—Racine, Milwaukee
Waterloo—Jefferson
Watertown—Jefferson
Waukesha—Waukesha, Milwaukee
Waupaca—Waupaca
Waupun—Dodge, Fond du Lac
Wausau—Marathon
Wausaukee—Marinette/Florence
Wautoma—Winnebago
Wauwatosa—Milwaukee, Waukesha, Ozaukee
West Allis—Milwaukee
West Bend—Washington
Westby—Vernon
Westfield—Green Lake
West Salem—La Crosse
Weyauwega—Waupaca
Whitefish Bay—Milwaukee
Whitehall—Trempealeau/Jackson/Buffalo
Whitewater—Walworth, Jefferson
Wild Rose—Green Lake
Wind Lake—Kenosha, Milwaukee, Racine
Winneconne—Winnebago
Wisconsin Dells—Columbia/Marquette/Adams, Juneau, Sauk
Wisconsin Rapids—Wood
Withee—Clark
Wonewoc—Juneau
Wood—Milwaukee, Waukesha
Woodruff—Marathon, Oneida/Vilas

Although typesetting for this Membership Directory took place in early December, the *Wisconsin Medical Journal* staff, in cooperation with the Membership Department, continued to make changes through December 31, thus providing the most current listing possible. Should there be inaccuracies or changes that should be included in a followup report, please notify the *WMJ* immediately. A form for such notification appears on the reverse side of this page.

Key to SPECIALTY CODES

(Shown directly above name, with primary specialty first, followed by secondary specialties)

Primary and secondary specialties in this directory have been reported to the Society by each individual physician listed. This information has not been verified with any other source. It is intended only for use in this directory and does not indicate specialty board certification or eligibility, nor is it to be used for changing or updating other records.

ADL	Adolescent Medicine
ADM	Administrative Medicine
AI	Allergy and Immunology
AM	Aerospace Medicine
A	Allergy
AN	Anesthesiology
BE	Broncho-Esophagology
BLB	Bloodbanking
C	Cardiology
CD	Cardiovascular Diseases
CT	Computerized Tomography
D	Dermatology
DMP	Dermatopathology
DIA	Diabetes
EEG	Electroencephalography
EM	Emergency Medicine
END	Endocrinology
FP	Family Practice
GE	Gastroenterology
GP	General Practice
GPM	General Preventive Medicine
GEN	Genetics
GER	Geriatrics
GYN	Gynecology
HEM	Hematology
HBM	Hyperbaric Medicine
HYP	Hypnosis
IG	Immunology
CLIG	Immunology, Clinical
ID	Infectious Diseases
INF	Infertility
INSM	Insurance Medicine
IM	Internal Medicine
LAR	Laryngology
LM	Legal Medicine
MFS	Maxillofacial Surgery
ND	Neoplastic Diseases
NEP	Nephrology
N	Neurology
NPM	Neonatal-Perinatal Medicine
CHN	Neurology, Child
NA	Neuropathology
NM	Nuclear Medicine
NR	Nuclear Radiology
NTR	Nutrition
OBS	Obstetrics
OBG	Obstetrics and Gynecology
OM	Occupational Medicine
ON	Oncology
RON	Oncology, Radiation
CLON	Oncology, Clinical
ONS	Oncology, Surgical
OPH	Ophthalmology
OT	Otology
OTO	Otorhinolaryngology
OTOHN	Otolaryngology, Head and Neck
PTH	Pathology
ATCLP	Pathology, Anatomic and Clinical
CLP	Pathology, Clinical
FOP	Pathology, Forensic
PD	Pediatrics
PDA	Pediatrics, Allergy
PDC	Pediatrics, Cardiology
PDE	Pediatric Endocrinology
PHO	Pediatric Hematology-Oncology
PNP	Pediatric Nephrology
PHA	Pharmacology
PA	Pharmacology, Clinical
PM	Physical Medicine and Rehabilitation
PHY	Physiology
P	Psychiatry
CHP	Psychiatry, Child
PYA	Psychoanalysis
PYM	Psychosomatic Medicine
PH	Public Health
PUD	Pulmonary Diseases
R	Radiology
DR	Radiology, Diagnostic
PDR	Radiology, Pediatric
TR	Radiology, Therapeutic
RHU	Rheumatology
RHI	Rhinology
RIP	Radioisotopic Pathology
ABS	Surgery, Abdominal
CDS	Surgery, Cardiovascular
CRS	Surgery, Colon and Rectal
GS	Surgery, General
HS	Surgery, Hand
HNS	Surgery, Head and Neck
NS	Surgery, Neurological
ORS	Surgery, Orthopedic
PDS	Surgery, Pediatric
PS	Surgery, Plastic
TS	Surgery, Thoracic
TRS	Surgery, Traumatic
U	Surgery, Urological
VS	Surgery, Vascular
PVS	Surgery, Peripheral Vascular
OS	Other; *ie,* physician designated a specialty other than those appearing here
US	Unspecified
RET	Retired

To: *Wisconsin Medical Journal,* Box 1109, Madison, Wisconsin 53701
Please correct my listing in the 1981-82 Membership Directory as follows:

COUNTY MEDICAL SOCIETY _____

SPECIALTIES _____ (PRIMARY) / _____ (SECONDARY) / _____

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE ( ) _____

SIGNED _____ DATE _____

ASHLAND BAYFIELD IRON
COUNTY MEDICAL SOCIETY

GP U
Bargholtz, William E
522 W 2nd St
Ashland WI 54806

AN
Blum, Carol A
2101 Beaser Ave
Ashland WI 54806

GS
Brown, Garfield W
2101 Beaser Ave, #5
Ashland WI 54806
(715) 682-6696

IM ON
Cadwell, Frank J
2101 Beaser Ave
Ashland WI 54806
(715) 682-6651

ORS
Chambers, James D
2101 Beaser Ave, #6
Ashland WI 54806
(715) 682-8183

FP
Christensen, Donnan L
320 Superior Ave
Washburn WI 54891

OPH
Doty, John W
1001 2nd St W
Ashland WI 54806
(715) 682-4515

R
Fischer, Markham J
2101 Beaser Ave, #4
Ashland WI 54806

OTO HNS
Hamp, James A
2101 Beaser Ave, #1
Ashland WI 54806
(715) 682-9311

GP
Jauquet, Joseph M
200 7th Ave W
Ashland WI 54806
(715) 682-4545

FP
Koeller, Arlyn A
206 6th Ave W
Ashland WI 54806
(715) 682-6622

GP GS
Kreher, John E
206 6th Ave W
Ashland WI 54806
(715) 682-6622

U
Krutsch, Kenneth N
Rt 2, POB 344
Washburn WI 54891
(715) 682-5506

U
Kurten, Timothy
Rt 3 POB 36
Ashland WI 54806
(715) 682-6584

GP GS
Larson, Harry H
320 Superior Ave
Washburn WI 54891
(715) 373-2216

DR R
Lind, Robert G
2101 Beaser Ave, #4
Ashland WI 54806

AN
Longstreth, Charles R
Rt 1 POB 163J
Ashland WI 54806

GP PUD
Martinetti, Dominic J
327 Silver St
Hurley WI 54534
(715) 561-2960

FP
McCue, John P
206 6th Ave W
Ashland WI 54806
(715) 682-4029

FP
Meece, Terrence
610 14th Ave W
Ashland WI 54806

P
Mercer, Wayne C
Superior Ave, POB 575
Washburn WI 54891
(715) 373-2295

OPH
Morrow, Kenneth A
Rt 1 Box 61A
Ashland WI 54806
(715) 682-4515

ORS
Olsen, Clark O
2101 Beaser Ave, #6
Ashland WI 54806
(715) 682-8183

FP
Oujiri, John C
2101 Beaser Ave, #2
Ashland WI 54806
(715) 682-2358

PTH CLP
Parker, Eugenia H
1615 Maple Lane
Ashland WI 54806

R
Peterson, John O
2101 Beaser Ave, #4
Ashland WI 54806

FP
Saarinen, David M
2101 Beaser Ave, #2
Ashland WI 54806
(715) 682-2358

OBG
Sandin, Howard N
2101 Beaser Ave, #9
Ashland WI 54806
(715) 682-5277

OPH
Sneed, Robert J
POB 233
Ashland WI 54806
(715) 682-4515

PD
Snowden, Thomas
Rt 1
Washburn WI 54891

IM
Soucheray, Philip H
2101 Beaser Ave, #3
Ashland WI 54806
(715) 682-5511

GP
Stanley, Robert A
200 7th Ave W
Ashland WI 54806
(715) 682-4545

GP
Telford, John G
320 Superior Ave
Washburn WI 54891
(715) 373-2216

GS VS
Teoh, Ivan
2101 Beaser Ave
Ashland WI 54806
(715) 682-9081

FP
Van Pernis, Paul
2101 Beaser Ave, #2
Ashland WI 54806
(715) 682-2358

OBG
Vernier, Edward M
2101 Beaser Ave, #9
Ashland WI 54806
(715) 682-5277

BARRON WASHBURN BURNETT
COUNTY MEOICAL SOCIETY

GP
Bannister, Frederick M
220 Douglas St
Chetek WI 54728

GS GP
Choudhuri, Bishnu P
707 Ash St
Spooner WI 54801
(715) 635-2151

GP
Cotts, Lloyd R
1020 Lakeshore Dr
Rice Lake WI 54868
(715) 234-9031

FP
Cragg, Michael M
1020 Lakeshore Dr
Rice Lake WI 54868
(715) 234-9031

FP
Damroth, Michael S
Rt 3
Chetek WI 54728

IM
Eastwold III, Conrad
1020 Lakeshore Dr
Rice Lake WI 54868
(715) 234-9031

GP
Eidsmoe, Noland A
810 S Main St
Rice Lake WI 54868
(715) 234-2611

U
Eschenbaum, Edward G
1035 N Main St
Rice Lake WI 54868
(715) 234-6874

FP
Flogstad, Duane L
Shell Lake WI 54871
(715) 468-2711

GS
Fogarty, James P
Rt 2 Box 304-C
Chetek WI 54728

FP
Goetsch, Frederick H
707 Ash St
Spooner WI 54801
(715) 635-2151

GP
Halberg, Avery C
Turtle Lake WI 54889
(715) 986-2240

FP GS
Hartzell, Richard L
POB 345
Grantsburg WI 54840
(715) 463-5317

GP
Hay, Alan J
205 Sheridan Circle
Charleston WV 25314

ORS GS
Healy, Patrick M
1035 N Main St
Rice Lake WI 54868
(715) 234-9018

GP
Henningsen, John T
1020 Lakeshore Dr
Rice Lake WI 54868
(715) 234-9031

FP GS
Hoyer, John K
1020 Lake St
Rice Lake WI 54868
(715) 234-9031

GS
Koob, Lynn D
1020 Lakeshore Dr
Rice Lake WI 54868
(715) 234-9031

GP
Kristensen, Lowell A
1020 Lakeshore Dr
Rice Lake WI 54868
(715) 234-9031

FP
Lingen, Thomas A
POB 127
Cumberland WI 54829
(715) 822-2231

GP
Lund, Robert E
POB 127
Cumberland WI 54829
(715) 822-2231

FP
Macy, Roger F
POB 127
Cumberland WI 54829
(715) 822-2231

GP
Maser, James F
1020 Lakeshore Dr
Rice Lake WI 54868
(715) 234-9031

GS ORS
Matson, Kenneth L
10738 Santa Fe Dr
Sun City AZ 85351
(602) 977-3568

All members are MDs (except some candidate members) unless otherwise indicated.

GP PD
Matzke, Rudolph W
707 Ash St
Spooner WI 54801
(715) 635-2151

P CLP
Melin, Bruce D
1100 N Main St
Rice Lake WI 54868
(715) 234-1515

FP
Narins, Voldemars
1020 Lakeshore Dr
Rice Lake WI 54868
(715) 234-9031

FP
Nymo, Mark T
1020 Lakeshore Dr
Rice Lake WI 54868
(715) 234-9031

GP
Olson, Lester J
624 Smith St
Spooner WI 54801
(715) 635-2432

R
Pelant, Thomas M
Rt 2 Box 52-2
Rice Lake WI 54868

GS
Quenan, James P
209 4th Ave W
Shell Lake WI 54871
(715) 468-2711

P
Rathbun, John M
POB 235
Cumberland WI 54829

FP
Rholl, Mark A
435 S 5th St
Barron WI 54812

P FP
Riemer, Donald E
POB 127
Cumberland WI 54829

GS
Schipitsch, Douglas A
1475 Webb St
Cumberland WI 54829
(715) 822-2231

GP
Strang, Clive J
1220 E Woodland Ave
Barron WI 54812
(715) 537-3166

FP
Thalacker, Howard A
220 Douglas St
Chetek WI 54728

FP
Thatcher, Gregory B
209 4th Ave W
Shell Lake WI 54871
(715) 468-2711

GP
Thompson, Lester A
1020 Lakeshore Dr
Rice Lake WI 54868
(715) 234-9031

GP AM
Whaley, Ralph C
1220 Woodland Ave
Barron WI 54812
(715) 537-3166

FP
Youngren, Thomas R
POB 127
Cumberland WI 54829
(715) 822-2231

BROWN
COUNTY MEDICAL SOCIETY

PD HEM
Adair, Stuart E
900 S Webster Ave
Green Bay WI 54301
(414) 437-0431

GS
Adamski, Val D
1313 Summer Range Rd
De Pere WI 54115

FP
Aldrich, Peri L
Box Z, 940 S St Augustine
Pulaski WI 54162
(414) 822-3111

GE IM
Amarnani, Narayan H
430 S Webster Ave
Green Bay WI 54301
(414) 433-0400

OPH
Andrew, Reed C
417 S Monroe St
Green Bay WI 54301
(414) 437-6505

CD IM
Anthony, Lewis G
704 S Webster Ave
Green Bay WI 54301
(414) 433-3640

OBG
Austin, Stephen D
704 S Webster Ave
Green Bay WI 54301
(414) 468-3444

PTH
Awen, Charles F
744 S Webster Ave
POB 1700
Green Bay WI 54305
(414) 433-3653

DR R
Babbitt, Lon D
POB 3006
Green Bay WI 54303
(414) 499-1428

PD
Barkow, Kathleen M
821 S Quincy
Green Bay WI 54301

ON IM
Bayer, Gerald K
336 Windward Dr
Green Bay WI 54302

OBG
Bechtel Jr, Richard C
704 S Webster Ave
Green Bay WI 54301
(414) 468-3444

OPH
Belson, Michael J
923 Eliza St
Green Bay WI 54301
(414) 432-9261

GS TS
Beno, Thomas J
1751 Deckner Ave
Green Bay WI 54302
(414) 468-5621

GS
Bishop, John C
1203 S Military Ave
Green Bay WI 54304
(414) 494-4781

PTH
Blackburn Jr, Marvin D
POB 1700
Green Bay WI 54305

OPH
Blahnik, Clarence L
1721 Lost Dauphin Rd
De Pere WI 54115
(414) 437-6505

GYN
Boersma, John J
519 S Monroe Ave
Green Bay WI 54301
(414) 437-5451

R
Bolich, Paul R
1586 Arapahoe Ct
Green Bay WI 54303

GS TS
Brault, Robert G
704 S Webster Ave
Green Bay WI 54301
(414) 468-7121

NS
Bressler, Bruce C
704 S Webster Ave
Green Bay WI 54301
(414) 465-1900

GP GS
Brusky, Alvin H
1203 S Military Ave
Green Bay WI 54304
(414) 494-4781

IM
Brusky, John D
1203 S Military Ave
Green Bay WI 54304
(414) 494-4781

IM
Buck, Charles E
1745 Dousman
Green Bay WI 54303
(414) 494-9661

P
Caffrey, James F
130 E Walnut St
Green Bay WI 54301
(414) 435-8920

R NM
Calaguan, Raymond R
POB 1221
Green Bay WI 54305

GP
Crawford, Chester W
704 S Webster Ave
Green Bay WI 54301
(414) 433-3456

IM
Cross, Michael W
900 S Webster Ave
Green Bay WI 54301
(414) 437-0431

TR NM
Cruz, Lorenzo R
3319 Miranda Court
Green Bay WI 54301
(414) 336-7383

GSCDS
Curl, James H
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Number of members by county medical society

as of December 31, 1981

Ashland-Bayfield-Iron	36
Barron-Washburn-Burnett	41
Brown	194
Calumet	11
Chippewa	37
Clark	13
Columbia-Marquette-Adams	31
Crawford	4
Dane	679
Dodge	48
Door-Kewaunee	26
Douglas	24
Eau Claire-Dunn-Pepin	142
Fond du Lac	95
Forest	2
Grant	22
Green	60
Green Lake-Waushara	19
Iowa	8
Jefferson	47
Juneau	10
Kenosha	105
La Crosse	175
Lafayette	1
Langlade	11
Lincoln	21
Manitowoc	65
Marathon	130
Marinette-Florence	27
Milwaukee	1403
Monroe	15
Oconto	9
Oneida-Vilas	66
Outagamie	149
Ozaukee	29
Pierce-St Croix	41
Polk	22
Portage	47
Price-Taylor	16
Racine	144
Richland	14
Rock	127
Rusk	10
Sauk	28
Sawyer	6
Shawano	18
Sheboygan	100
Trempealeau-Jackson-Buffalo	21
Vernon	15
Walworth	29
Washington	56
Waukesha	258
Waupaca	29
Winnebago	185
Wood	192
Total	5113

THE STATE MEDICAL SOCIETY OF WISCONSIN

*Created by the Territorial Legislature in 1841. . .*representing nearly 5,000 member physicians in Wisconsin, comprising 55 county medical societies and 23 medical specialty sections. The purpose of the Society is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society include continuing medical education, peer review, legislation, community health education, scientific affairs, socio-economics, health planning, services for physicians, operation of a Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal.*

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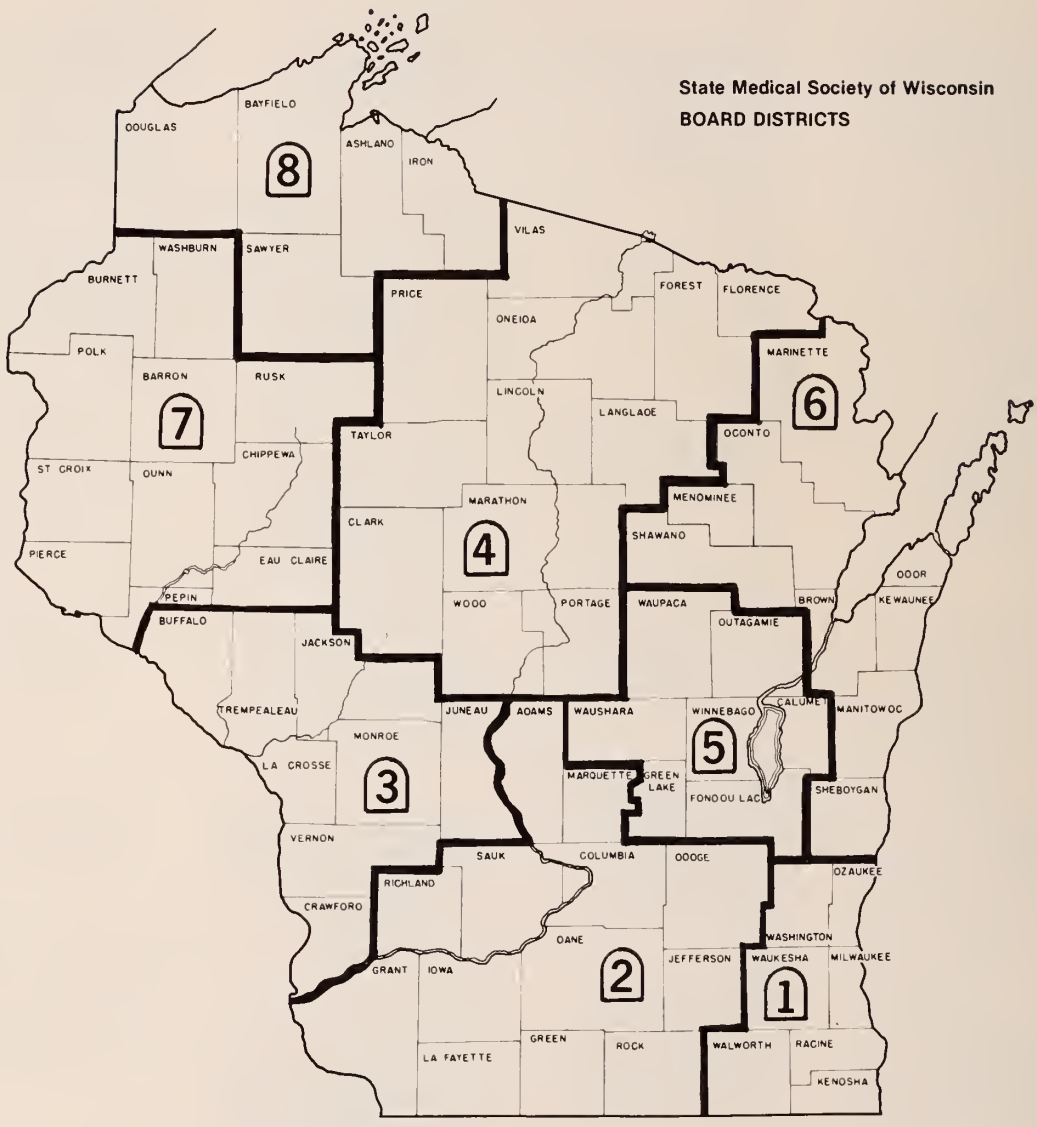

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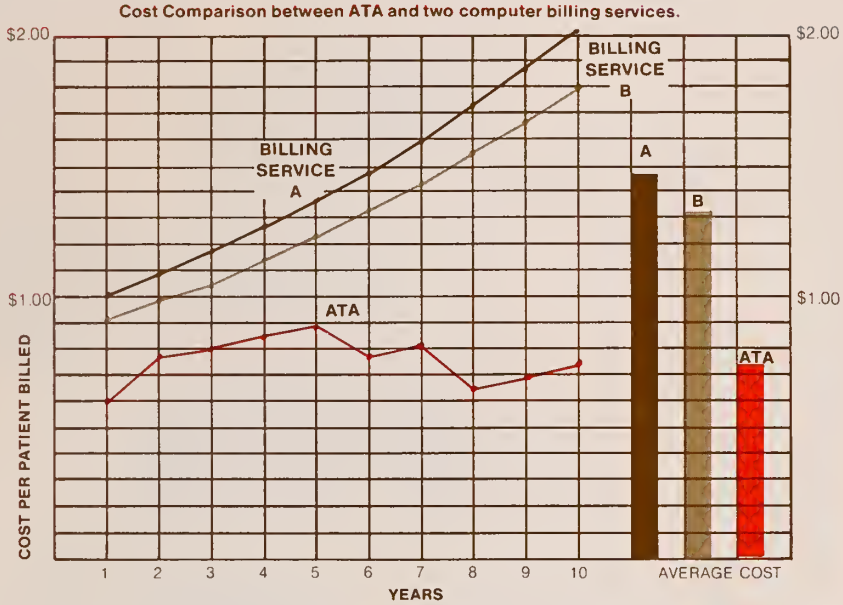

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First Class First Aid

- Broad-spectrum antibacterial
- Handy applicator tip

DESCRIPTION: Each gram contains: Aerosporin* (Polymyxin B Sulfate) 5,000 units, bacitracin zinc 400 units, neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base), special white petrolatum qs; in tubes of 1 oz and ½ oz and 1/32 oz (approx.) foil packets.

INDICATIONS: *Therapeutically* (as an adjunct to systemic therapy when indicated), for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection. *Prophylactically*, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: Not for use in the eyes or in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching, it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

AOVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

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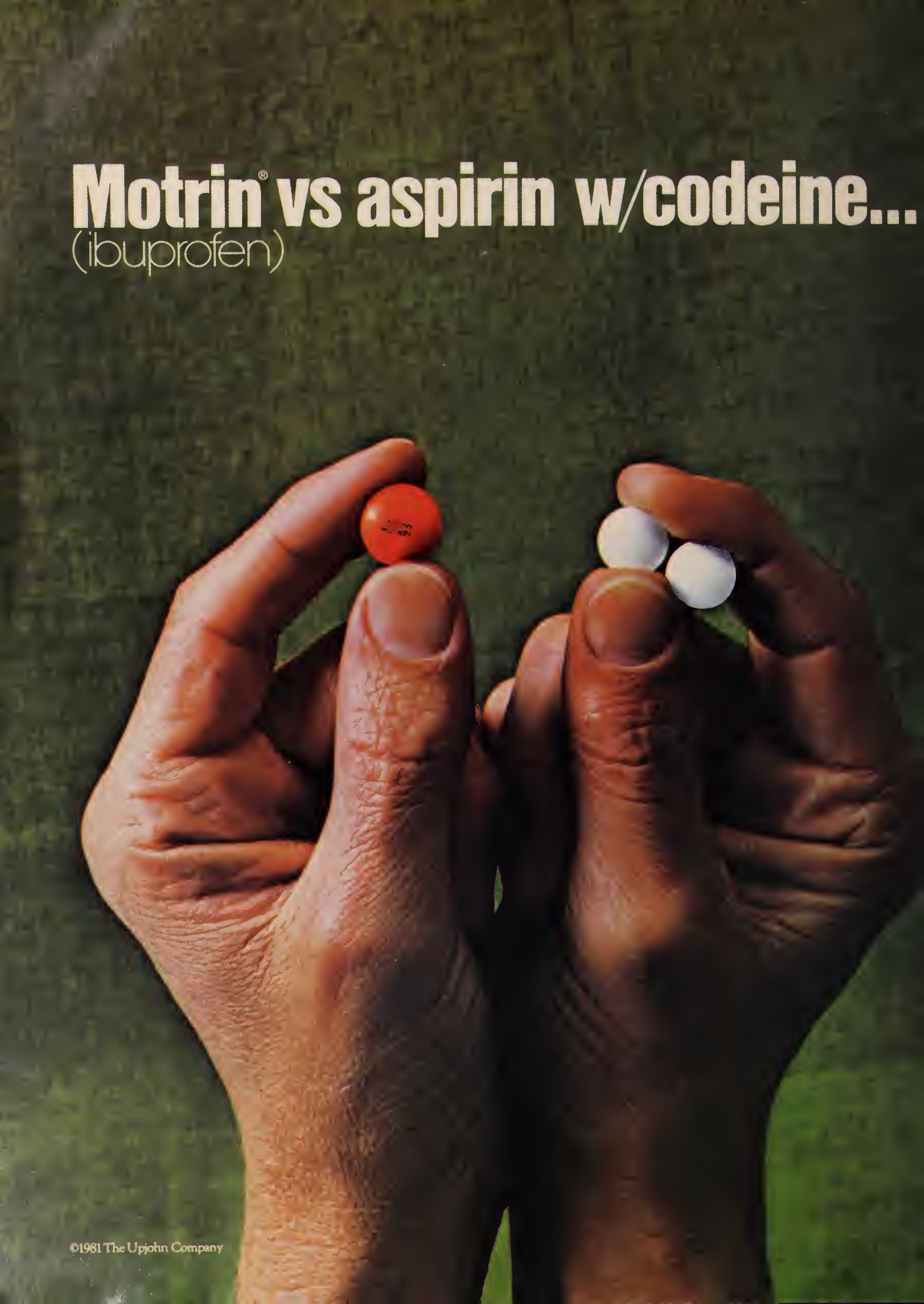
Motrin® vs aspirin w/codeine...
(ibuprofen)



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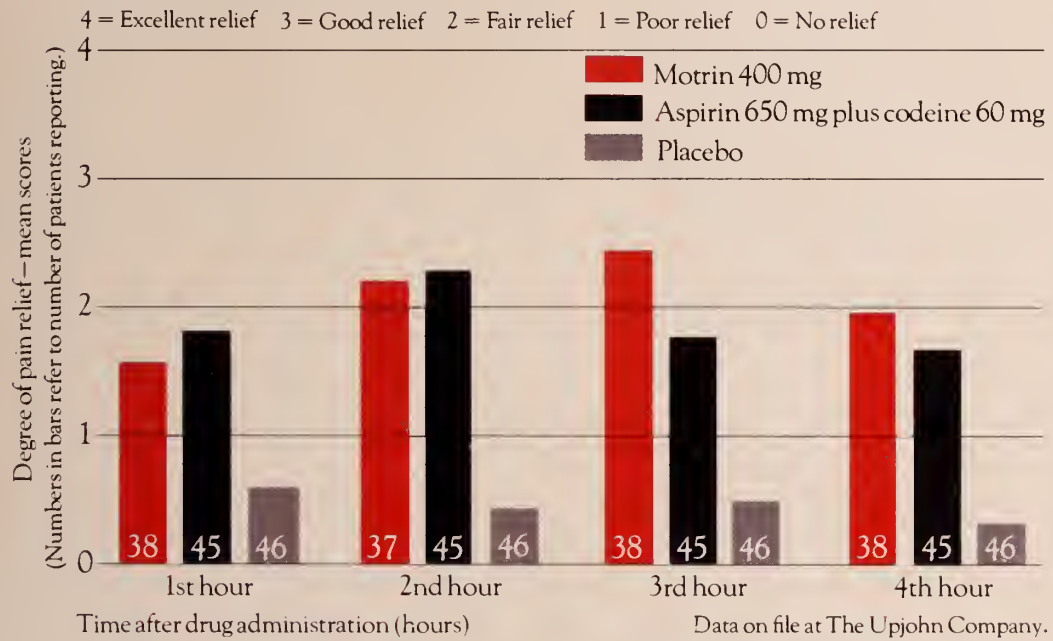
compare the analgesic effect

A *Motrin* 400 mg dose relieved postsurgical dental pain as effectively as a combination of 650 mg aspirin and 60 mg codeine (two aspirin-with-codeine No. 3 tablets) in a study of 129 patients. In this double-blind, placebo-controlled, randomized study, no statistically significant difference in relief of pain was noted at 1, 2, and 4 hours between the *Motrin* and aspirin-with-codeine groups... with *Motrin* being significantly more effective ($p = 0.03$) at the three-hour interval. Active treatment was significantly more effective ($p < 0.0001$) than placebo at all time intervals.

Comparison of pain relief
Motrin vs aspirin-codeine combination



Data on file at The Upjohn Company.

One tablet q4-6h prn
For relief of mild to moderate pain:

Motrin® 400 mg TABLETS
ibuprofen, Upjohn

• Not a narcotic • Not addictive • Not habit forming • Nonscheduled • Acts peripherally • Relieves pain rapidly • Relieves inflammation • Indicated in acute and chronic pain • Well tolerated (The most common side effect with *Motrin* is mild gastrointestinal disturbance.)

Please turn the page for a brief summary of prescribing information.

Upjohn

Motrin® (ibuprofen)
now proved an effective analgesic for mild to moderate pain

Motrin® Tablets (ibuprofen, Upjohn)

Indications and Usage: Relief of mild to moderate pain

Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS)

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. *Aspirin*: Used concomitantly may decrease Motrin blood levels. *Coumarin*: Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy nor by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin is gastrointestinal (4% to 16%). This includes nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness,* headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Rheumatoid arthritis and osteoarthritis, including flares of chronic disease: Suggested dosage is 300, 400, or 600 mg t.i.d. or q.i.d. Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain.

Do not exceed 2400 mg per day.

Caution: Federal law prohibits dispensing without prescription.

For additional product information, see your Upjohn representative or consult the package insert.

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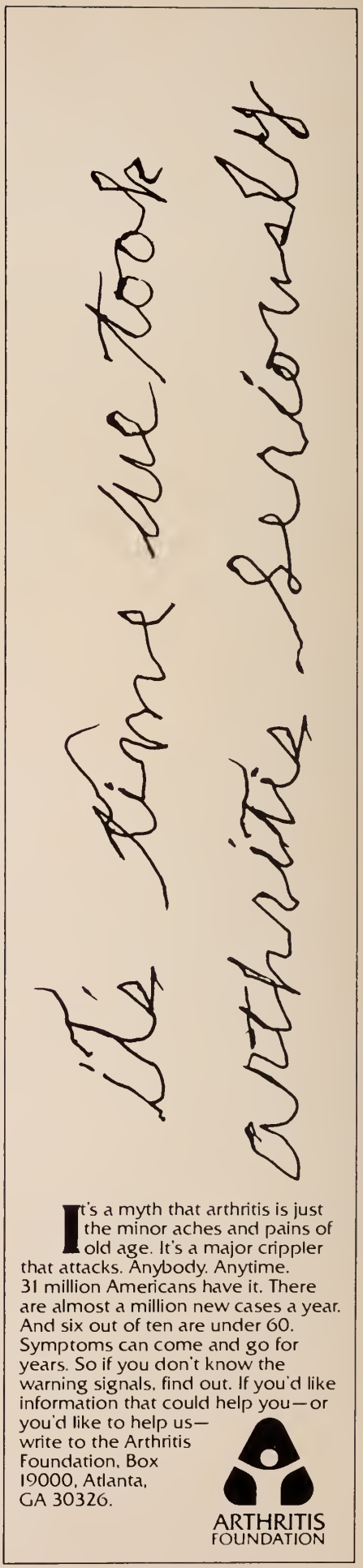
MARCH 1981



It's a myth that arthritis is just the minor aches and pains of old age. It's a major crippler that attacks. Anybody. Anytime. 31 million Americans have it. There are almost a million new cases a year. And six out of ten are under 60. Symptoms can come and go for years. So if you don't know the warning signals, find out. If you'd like information that could help you—or you'd like to help us—write to the Arthritis Foundation, Box 19000, Atlanta, GA 30326.

ARTHRITIS FOUNDATION

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RATES: 40¢ per word, with a minimum charge of $16.00 per ad. BOXED AD RATES: $32.00 per column inch. DEADLINE: Copy must be received by the 20th of the month preceding month of issue; e.g., copy for the August issue is due July 20. Send copy to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 800/362-9080.

Physicians Exchange

Family Practice opportunity in branch clinic of the Albert Lea Clinic, PA, at New Richland, Minnesota. This is an outstanding opportunity for a rural physician to be associated with an old established group practice that has a new and established facility in its peripheral community. The Albert Lea Clinic, PA, is a sixteen-man multispecialty group in primary and secondary care fields. Top salary is available the first year. Senior physician participation beginning at the end of the first year with an incentive income distribution plan. Low cost buy-in. Maximum profit-sharing plan. A top level personal insurance plan and full range of other benefits including malpractice insurance. There is a new hospital in the city of Albert Lea. New Richland is a fine small town in which to live and is centrally located in the Minneapolis-St Paul, Rochester Mayo, Albert Lea area. Please contact B J Boss, Administrator, Albert Lea Clinic, PA, 1602 Fountain St, Albert Lea, Mn 56007; ph 507/373-8251, personal phone 507/377-1406 or contact T F Thompson, MD, 507/373-8251, personal phone 507/373-0259. 1/82

Green Bay, Wisconsin. Well established fee-for-service group in regional trauma/poison center seeks additional physician. $35,000 plus annual visits. Competitive salary with paid liability, CME, pension/profit sharing. Excellent recreational and educational opportunities. Great place to raise a family. Send CV to: A W Haines, MD, 435 Shady Drive, Oneida, WI 54155; ph 414/865-7740. 1tfn/82

Physician wanted to perform light physicals on a full or part-time basis. Ideal job for retiring physician. Contact Mike Stough collect at 513/621-8728. 10 tfn/81

Large nursing and rehabilitation center in Milwaukee seeking a physician as the inhouse staff physician and medical director. Complete lab and x-ray facilities. Office and examining facilities included. We are prepared to offer an attractive package consisting of an excellent base salary, health, and disability insurance coverage, a very generous tax-exempt and pension plan, and auto. Contact Dept 497 in care of the Journal. 1/82

PRIMARY CARE PHYSICIANS
BOARD CERTIFIED OR ELIGIBLE

We represent over 50 communities throughout the state which are seeking quality primary care physicians. These communities offer established service areas, generous practice and financial arrangements.

CONTACT:
Laurie Glowac or Fred Moskol
New Physicians for Wisconsin
University of Wisconsin Department of Family Medicine
777 South Mills Street, Madison, Wisconsin 53715
Phone: 608/263-4095

1-12/82

The Racine Medical Clinic, a progressive cluster corporation of 25 physicians, is currently seeking an orthopedic surgeon and an invasive cardiologist. Full benefits, unlimited earnings and a full and exciting practice are offered. Please contact: Roger D Lacock, Administrator, Racine Medical Clinic, 5625 Washington Ave, Racine, WI 53406; ph 414/886-5000. 1tfn/82

Family physician, Board Certified or Eligible, to join four-man family practice group in northwest Wisconsin. First-year guaranteed salary. New clinic building located adjacent to 46-bed hospital, in the heart of Wisconsin's vacationland. Call shared with other family practice physicians in area, weekend coverage contracted. Jeanne Chamberlain, Adm, Spooner Clinic Ltd, 707 Ash St, Spooner, Wis 54801. Ph 715/635-2151. 12/81-5/82

Fond du Lac—26 physician incorporated multispecialty group on the south shore of Lake Winnebago needs a fourth pediatrician. Guaranteed salary with full shareholder status available after one year. Send CV to Kirk A Veit, MD, 80 Sheboygan St, Fond du Lac, Wis 54935. 9tfn/81

Family Practitioners to work in community clinics near Madison, Wisconsin. Combination of a community office practice with privileges at major Madison hospitals. Family practitioner will join an already established internist to continue the growth of a medical practice, expand a small pediatric practice, and begin an obstetrical practice. Clinics are full service and have professional personnel support. Physicians have a guaranteed compensation package and an option to purchase the clinic from the community. Please send resume to T Arnfelt, Madison General Hospital, 202 South Park St, Madison, Wis 53715. 1-2/82

Physician wanted to share fully equipped medical office, x-ray, lab, fully staffed, small community, northern Wisconsin. Contact Dept 496 in care of the Journal. 12tfn/81

Medical Director. Rapidly expanding mental health center in need of a Medical Director who would be responsible for the administration of medical care and for the medical treatment of all patients of the Center. Specific duties will include organization and performance of the Quality Assurance Program, preventative and consultative services, provision of medical evaluations, scheduling of psychiatric time for case staffing, and 24-hour psychiatric coverage. Excellent opportunity for a dynamic psychiatrist interested in community mental health and seeking a challenge. Applicants must be Board certified or eligible in psychiatry and licensed in the state of Indiana. Must have successfully completed a three-year residency approved by the American Board of Psychiatry and Neurology. At least 2 years experience in a related field and/or experience working with a multi-disciplinary staff is preferred. Salary range $60,000-$75,000 annually. Attractive fringe benefits package. Facilities located 30 minutes from downtown Chicago. Send resume to: Danita Smith, Personnel Manager, (219) 398-7050, TRI-CITY COMMUNITY MENTAL HEALTH CENTER, 3901 Indianapolis Blvd, East Chicago, IN 46312. An Equal Opportunity Employer. 1/82

Physicians Exchange

continued

Wausau Medical Center, SC, a 50-physician multispecialty group has openings for physicians in the following specialties. *Family Practice, Hematology/Oncology, Neurology* and *Otolaryngology.* Competitive first-year salary, incentive plan thereafter. Comprehensive fringe benefits. New facility near new hospital. Located in beautiful, quiet, central Wisconsin, metropolitan area of 65,000. Recreational opportunities abundant. For more information contact: K L Day, MD, Wausau Medical Center, SC, 2727 Plaza Drive, Wausau, Wis 54401, or call collect 715/847-3351. 7tfn/81

Fifty physician multispecialty clinic in West Central Wisconsin wants cardiologist (non-invasive), neonatologist, neurologist, neurosurgeon, orthopedic surgeon, and otolaryngologist. Excellent cultural, educational, and recreational facilities. 90 miles from Minneapolis. Please contact James R Jepson, Administrator, Midelfort Clinic, Ltd, 733 West Clairemont Ave, Eau Claire, Wis 54702 or call (715) 839-5266. 1-3/82

Family Practitioner to join a 50-physician multispecialty group with an 11-man Family Practice Department. Several challenging opportunities available in satellite practice. Initial guaranteed salary and excellent fringe benefits available. City of 50,000 on the Mississippi River. Outstanding place to live, work, and enjoy varied cultural and recreational opportunities. Contact: Medical Director, Skemp-Grandview-La Crosse Clinic, 815 S 10th St, La Crosse, Wis 54601; ph 608/782-9760. 11-12/81; 1/82

Family Practice. General Clinic—Jackson. Two family physicians for the Jackson Branch of a 12-man multispecialty clinic which includes (5) family practitioners, (4) internists, (2) pediatricians, and a general and vascular surgeon. Located 25 miles north of Milwaukee in a fast growing scenic area. Modern 120-bed hospital. Inquire: General Clinic of West Bend, Inc, 279 South 17th Ave, West Bend, Wis 53095. Phone: 414/338-1123. 11tfn/80

Two Family Practice Physicians sought to assume a fully operational practice in a community 30 miles north of Madison, Wisconsin. New clinic facility. Income guaranteed. Physician back-up available. Board certified or eligible preferred. Contact John P Rahm, MD, 6105 Ridgewood Ave, Madison, Wis 53716. 5tfn/81

Medical Ophthalmologist wanted to join established, growing practice in beautiful Lake Tahoe-Reno, Nevada area. Excellent climate and year-round recreational facilities. Will consider full or part-time or retired physician. Contact Karen Grodowitz, MS, Executive Director, Reno Eye Clinic, 1530 E 6th St, Reno, Nev 89512; ph 702/329-1389. 10tfn/81

Staff Psychiatrist. Full-time position for a staff psychiatrist in an expanding community mental health center serving a catchment area population of approximately 204,000. Position requires provision of psychiatric consultations, psychiatric evaluations, and direct services within the outpatient and partial hospitalization programs. Board certification or eligibility required. Experience in a related field and/or experience working with a multidisciplinary staff is preferred. Salary range $44,000-$66,000 annually. Attractive fringe benefits package. Facilities located 30 minutes from downtown Chicago. Send resume to: Danita Smith, Personnel Manager, (219) 398-7050, TRI-CITY COMMUNITY MENTAL HEALTH CENTER, 3901 Indianapolis Blvd, East Chicago, IN 46312. An Equal Opportunity Employer M/F. 1/82

Faculty Member Family Practice Program. The Black Hawk Area Medical Education Foundation is recruiting a Board Certified Family Physician to join its Family Practice Residency Program in Waterloo, Iowa. The program is community-based, affiliated with the University of Iowa College of Medicine, and part of the Iowa Network of Family Practice Residency Programs. The Waterloo metropolitan area has 125,000 people, four hospitals, and is well represented in the medical specialties. Applicants should have a MD degree, be eligible for licensure in Iowa, and should have several years of practice experience. Major duties include teaching residents in all aspects of patient care, including obstetrics, and also providing patient care. Other duties include some program administration and assisting in research from time to time. A salary in the range of $60,000 per year with an additional 20% fringe benefit package is offered. Other fringe benefits relating to retirement, moving expenses, and continuing education are provided. Please submit your resume to: Charles A Waterbury, MD, Program Director, Black Hawk Area Medical Education Foundation, 441 East San Marnan Dr, Waterloo, Iowa 50702; ph (319) 234-4419. Equal Opportunity Employer. 1-4/82

Family Practice immediate opening. Join 22-physician multispecialty group in Appleton, Wisconsin. Excellent hospitals, guarantee plus incentive compensation. Complete benefit package. Medium-size community. Contact Art Schuetze, Administrator, Medical Arts Clinic, SC, 401 N Oneida St, Appleton, Wis 54911; ph 414/739-0171. 11-12/81; 1/82

Immediate opening for General and Child Psychiatrist to join well-established clinic in a community of 50,000. Large referral area. Two excellent hospitals. University and industrial area. Salary open. Excellent benefits. Contact: J M Tobin, MD, Northwest Psychiatric Clinic, Box 224, Eau Claire, Wis 54701; ph 715/834-2751. 12/81; 1-3/82

Family Practice and Urology positions available with an 18-member multispecialty group corporate practice. Modern clinic facility in Northeastern Wisconsin city of 100,000 enjoying a healthy and stable economy. Excellent recreational, educational, hospital, civic advantages. Please call collect or write: W J Mommaerts, Clinic Manager, West Side Clinic, SC, 1551 Dousman St, Green Bay, WI 54303; ph 414/494-5611. 1-4/82

Surgeon with Thoracic general vascular training and Ophthalmologist to join a progressive multispecialty group of 17 physicians consisting of General/Family Medicine, General Surgery, Internal Medicine, OB-GYN, Ophthalmology, Orthopaedic Surgeon, Pediatrics/Adolescent Medicine, and Radiology. Subspecialties include: Pathology, Vascular Surgery, Cardiovascular Diseases, Gastroenterology and Endoscopy. We are located in a fast growing, scenic, lake country area between Milwaukee and Madison and can offer excellent hospital, schools and recreational facilities. Full fringe benefit package. Contact: James F Dowd, Admin, Wilkinson Clinic, SC, 915 East Summit Ave, Oconomowoc, Wis 53066; ph 414/567-4433. 9tfn/81

PUT EXPERIENCE TO WORK FOR YOU WHILE YOU SEARCH FOR A NEW CHALLENGE

Let years of experience as a healthcare professional and a Placement Counselor assist you in finding a new location with a new challenge. Physicians in all specialties are urgently needed throughout the country. Many types of situations available. Confidentiality assured.

Contact Donna Herschleb, RN
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5222 Painted Post Drive, Madison, Wisconsin 53716
Phone: (608) 222-2927 *Licensed Employment Agency*

Professional FP Locum Tenens available. Board certified family practice. Wide range of experience including OB and ER. Prefer 1-2 week periods. $1800 per week plus room and travel. Write 5695 Mary Lane, Excelsior, Minn 55331; ph 612/474-4372. 11-12/81; 1/82

Wanted. Board certified or eligible orthopedic surgeon to practice in conjunction with a 5-member surgery department in a 22-member multispecialty group. Present surgical specialties: thoracic and vascular surgery, general surgery and urology. The group is located in the upper midwest, in a city of 100,000 between two major metropolitan areas of greater than one million. If interested, please send CV to: Stephen Wagner, Kurten Medical Group, SC, 2405 Northwestern Ave, Racine, Wis 53404. All inquiries will be kept confidential. 12tfn/80

Internist/Generalist/Family Practitioner: Position available in 300-bed active psychiatric rural hospital. Fully JCAH accredited. Three-year Psychiatric Residency Program. All treatment modalities. Numerous affiliated educational programs. Near metropolitan and recreational areas. Relaxed, low crime, low turmoil area. Salary range $47,902-$58,282 depending upon qualifications. Good fringe package and possibility of some private practice. Position involves directing a 15-bed medical-surgical unit and provide consultation to psychiatric staff. Contact Superintendent, Mental Health Institute, Independence, Iowa 50644; ph 319/334-2583. Equal Opportunity Employer. 12/81; 1-2/82

Grow with us in the Sunbelt. The INA Healthplan needs physicians in family practice and most specialties in Miami, Tampa, Dallas, Phoenix, Tucson, and Los Angeles. Attractive salaries and comprehensive benefits including professional development, retirement, and profit sharing programs are provided. If team interaction and casual living interest you, send a brief CV to Medical Administration, INA Healthplan, Inc, 7616 LBJ Freeway, Suite 303, Dallas, Tex 75251. 12/81; 1-2/82

Emergency Physician-Wausau, Wisconsin. Fee-for-service corporation with excellent income and benefits. New facility with excellent backup of all specialties. Generous time off to enjoy this family and sportsman's paradise. Emergency Medicine or Family Practice residency or Emergency Medicine Board certified required. Send CV or call Fred Klemm, MD, 2404 Hawthorne Lane, Wausau, Wis 54401; ph 715/842-9373. p11-12/81/1-82

Pediatrician to join 13-man multispecialty group. Many corporate benefits. Rapidly growing community of 25,000 located 30 miles north of Milwaukee. New hospital facilities. Inquire: General Clinic of West Bend, Inc, 279 South 17th Ave, West Bend, Wis 53095. 9tfn/79

General Surgeon. Board eligible/certified to join primary care group of six family physicians. Well established, rural setting, preceptor University of Wisconsin, JCAH 70-bed hospital. Send CV to: Gary Petersen, MD, Krohn Clinic, Ltd, 610 W Adams St, Black River Falls, Wis 54615. 10 tfn/81

Dermatologist, Rheumatologist, Oncologist needed to join multispecialty group of 33 physicians dedicated to primary care in East Central Wisconsin community. City population 48,000, drawing area 100,000. Attractive income arrangements, association membership possible after one year, pension and profit sharing, extensive fringe benefits. Contact: R B Windsor, MD, 1011 North 8th St, Sheboygan, Wis 53081; ph 414/457-4461. 12tfn/81

Medical Facilities

For Sale. General medical practice 5 years—gross $125,000 per year. Four-day week. Totally equipped, excellent clientele and prestige community. Will introduce. Year around beach front. South Laguna, Calif. Tel: 714/499-4360. Reason for retiring—health. 1/82

Green Bay, Wisconsin new prime office space across from new St Mary's Hospital. Lease or purchase options. Dr J Van Miller, phone 414/499-4241. 12tfn/79

Family Practice. Established, independent practice in equipped office. Small city in recreational area. Continued care of patients main interest. Contact: KL Haman, MD, 199 South Division, Waupaca, Wis 54981; ph 715/258-2707. 11tfn/81

Immediate solo practice available in Jefferson, Wisconsin, due to the recent death of Richard H Siedenburg, MD. Expandable building with three large lots available. Lease or purchase. Contact Miller Law Office, PO Box 417, Jefferson, Wisconsin 53549; ph 414/674-3345. g11tfn/81

Port Washington, Wisconsin. New prime office space in professional building. Upper level already occupied by three internists (specializing in cardiology), one dentist, and three doctors of chiropractic. Lower level has 700-2500 sq ft. Area needs obstetrician-gynecologist, pediatricians, urologist, dermatologist, and general practitioner. Phone 414/375-3010 or 414/284-0500 or write 1032 S Spring St, Port Washington, Wis 53074. 12/81; 1-2/82

For Sale—office lease and practice. Death of physician necessitates rapid sale of this active solo general practice. On west side of Milwaukee's metro area. Arrangements negotiable. Contact L C Boryc DDS; ph 414/781-9585. 12/81; 1/82

Prime east Madison medical office space to share. 2000 sq ft. Fully equipped and well furnished. Private office and sound proof examining rooms. X-ray, lab, and physical therapy facility on premises. Equipped minor surgery room. Share rent and staff expenses on a 50-50 basis or prorated to your needs. For more information and appointment to view facility, call C A Gencheff, DO: 608/241-3451. 12/81-1/82*

Miscellaneous

Physician's Assistant seeks relocation. Have national-Wisconsin state certification. Experience in rural primary care and general surgery. Prefer small community or rural family practice in Southeastern Wisconsin. Resume and references upon request. Contact Dept 494 in care of the Journal. 9tfn/81

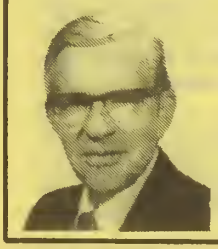
Author's editor. Technical assistance for your manuscripts and medical writing. K M Lopate, Picas Anon, 235 N Eastmoor, Brookfield, Wis 53005; ph 414/786-3922. 1tfn/82

Real Estate

For Sale. Cottage. Wild Rose, Wisconsin. South-facing with 150 feet lake frontage on one of the best fishing lakes in the area. Front deck offers the best view on the lake. Surrounded by woods. Some of the best hunting and fishing in state, and a good ski hill 5 minutes away. Call 612/894-6076. 12tfn/81

Farm For Sale by owner. 150 acres with buildings. Dane County. Save broker's fees. Low interest land contract or your choice. Resume describing location, land buildings. Price will be sent to inquirers. Write Box 171, Mt Horeb, Wis 53572-0171. p1/82

CONSULTANT FOR FLORIDA REAL ESTATE



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Meetings/CME Courses

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates: 40¢ per word, with a minimum charge of $16.00 per listing. BOXED LISTINGS: $32.00 per column inch. COPY DEADLINE for Continuing Medical Education listings is tenth of the month preceding the month of publication; e.g., copy for the August issue is due by July 10. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 800/362-9080. For listing of other meetings see the Special issue of the Journal of the American Medical Association: Continuing Education Courses for Physicians for period Sept 1, 1981 through Aug 31, 1982.

WISCONSIN

FEBRUARY 9-11, 1982: *Nineteenth Annual Telemark Symposium and Ski Outing,* Telemark Lodge, Cable. Sponsored by the Indianhead Chapter of the Wisconsin Academy of Family Physicians. Approved six credit hours Category I of AMA-PRA and AAFP. Info: Robert H Herzog, Wisconsin Academy of Family Physicians, 850 Elm Grove Rd, Elm Grove, Wis 53122; ph 414/784-3656.

FEBRUARY 16, 1982: Milwaukee Academy of Medicine program—*Chronobiology of Man: Relation to Delayed Sleep Phase Insomnia,* Rogers Memorial, Milwaukee, by Elliot Weitzman, MD, Professor of Neurology, Montefiore Hospital, Bronx, NY. Info: Milwaukee Academy of Medicine, PO Box 26509, 8701 Watertown Plank Road, Milwaukee, WI 53226 (phone 414/257-8249).

FEBRUARY 23, 1982: Milwaukee Ophthalmological Society, University Club, 924 E Wells St, Milwaukee 53202. Speaker: Dr Juan Arentsen, Wills Eye Hospital. Dinner at 6:30 pm and meeting at 7:30 pm. Info: Contact John Ridley, MD, 2315 N Lake Dr, Seton Tower, #1001, Milwaukee, Wis 53211; ph 414/278-7500.

FEBRUARY 25-28, 1982: Wisconsin Psychiatric Association, Lake Lawn Lodge, Lake Delavan.

STATE MEDICAL SOCIETY OF WISCONSIN
Dates and Locations of Annual Meetings
1982-1992

All meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) and the new Hyatt Regency as the headquarters hotel with the exception of 1985, when the meeting will be held at the LaCrosse Convention Center.

1982—May 13-15	**1987—Mar 26-28**
1983—Mar 24-26	**1988—Apr 28-30**
1984—Mar 29-31	**1989—Apr 13-15**
1985—Apr 25-27	**1990—Apr 26-28**
1986—Apr 17-19	**1991—Apr 18-20**
	1992—Apr 23-25

Meeting days will be Thursday and Friday; the first session of the House of Delegates will convene on Thursday, the second and third on Friday. Scientific programming will be on Friday and Saturday.

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701. Local telephone: 257-6781; toll-free in Wisconsin: 1-800/362-9080.

FEBRUARY 26-27, 1982: *Clinical Genetics for Primary Care Physicians,* Madison. Sponsored by Department of Medical Genetics, University of Wisconsin; and Continuing Medical Education, University of Wisconsin-Extension. Credit: AMA Category I, AAFP, AOA. Info: Sarah Z Aslakson, Continuing Medical Education, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

FEBRUARY 27, 1982: Wisconsin Dermatological Society, UW Center for Health Sciences, Madison.

MARCH 4-5, 1982: *First Annual Symposium on Chronic Obstructive Pulmonary Diseases,* Madison. Sponsored by Continuing Medical Education, Health and Human Services Area, University of Wisconsin-Extension; the Pulmonary Section, School of Medicine; and the Department of Nursing, University of Wisconsin, Madison; and the Respiratory Therapy Department, Center for Trauma and Life Support, Center for Health Sciences, University of Wisconsin, Madison. Thirteen credit hours Category I of AMA; AOA, Wisconsin Nurses Association and Family Practice credit applied for; University of Wisconsin-Extension 1.3 CEUs. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

MARCH 4, 1982: *Changing Strategies in the Treatment of Breast Cancer,* by Paul Carbone, MD, Madison. Sponsored by Berlin Memorial Hospital. Approved 2 credit hours of Category I. Info: Linda E Nevers, Berlin Memorial Hospital, 225 Memorial Dr, Berlin, Wis 54923; ph 414/361-1313.

MARCH 12-13, 1982: The American Heart Association's Advanced Cardiac Life Support Course in cooperation with Marshfield Clinic and Marshfield Medical Foundation, at Marshfield Clinic, Marshfield. Approved 14 ¼ credit Category I of AMA-PRA and AAFP. Fee: $200, advanced registration is required. Enrollment is limited. Deadline for registration is March 5, 1982. Info: Marshfield Clinic Office of Medical Education, 1000 North Oak, Marshfield, Wis 54449; ph 715/387-5207.

MARCH 16, 1982: Milwaukee Academy of Medicine program—*Some Favorite JAMA Covers,* by Therese Southgate, MD, Deputy Editor, JAMA, Chicago, IL. Info: Milwaukee Academy of Medicine, PO Box 26509, 8701 Watertown Plank Road, Milwaukee, WI 53226 (phone 414/257-8249).

MARCH 25-26, 1982: *6th Annual Ophthalmology Current Concepts Seminar '82,* at Inn on the Park Hotel, Madison. Sponsored by University of Wisconsin, School of Medicine, Dept of Ophthalmology; and University of Wisconsin-Extension, Dept of Continuing Medical Education. Credit applied for Category 1 of AMA-PRA. Fee: $155. Info: Sarah Z Aslakson, Continuing Medical Education, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

APRIL 14-16, 1982: Third Annual Madison Clinic Conference, *Therapeutic Management of Cardiovascular Diseases.* Sponsored by Extension Services in Pharmacy and the School of Pharmacy, University of Wisconsin, Madison. Info: Alan L

Hanson, PhD, Extension Services in Pharmacy, School of Pharmacy, 425 N Charter St, Madison, Wis 53706; ph 608/262-3130.

APRIL 16-17, 1982: *Second Annual General Surgery Conference: Breast and Endocrine Disease,* University of Wisconsin Clinical Science Center, Madison. Sponsored by University of Wisconsin Dept of Surgery, University of Wisconsin-Extension Dept of Continuing Medical Education. Approved 9 credit hours AMA Category I, UW Extension CEUs. Fee: $155 physicians; $100 residents, nurses, others. Info: Sarah Z Aslakson, Continuing Medical Education, 465B WARF Bldg, 610 Walnut St, Madison, WI 53706; ph 608/263-2856.

APRIL 20, 1982: Milwaukee Academy of Medicine program—*Clinimetrics: An Additional Basic Science for Clinical Medicine,* AOA Lecture, by Alvan Feinstein, MD, Professor of Medicine and Epidemiology, Yale University, New Haven, CT. Info: Milwaukee Academy of Medicine, PO Box 26509, 8701 Watertown Plank Road, Milwaukee, WI 53226 (phone 414/257-8249).

APRIL 27, 1982: Milwaukee Ophthalmological Society, University Club, 924 E Wells St, Milwaukee, Wis 53202. Speaker: Dr J A McCrary, Baylor College of Medicine. Dinner at 6:30 pm and meeting at 7:30 pm. Info: John Ridley MD, 2315 N Lake Dr, Seton Tower, #1001, Milwaukee, Wis 53211; ph 414/278-7500.

WISCONSIN SPECIALTY SOCIETY MEETINGS: 1982

Wisconsin Psychiatric Association, Feb 25-28, 1982, Lake Lawn Lodge, Lake Delavan

Wisconsin Dermatological Society, Feb 27, 1982, UW Center for Health Sciences, Madison

Wisconsin Urological Society, Apr 30-May 1, 1982, Concourse Hotel, Madison

Wisconsin Chapter: American Academy of Pediatrics, May 23-25, 1982, Playboy Club, Lake Geneva

Wisconsin Academy of Family Physicians, June 16-19, 1982, Radisson Hotel, La Crosse

Wisconsin Society of Obstetrics & Gynecology, July 23-24, 1982, Leathem Smith Lodge, Sturgeon Bay

Wisconsin Surgical Society, Sept 9-10, 1982, La Crosse

Wisconsin Society of Internal Medicine, Sept 9-11, 1982, Holiday Inn (Downtown), Green Bay

Wisconsin Society of Anesthesiologists, Sept 9-12, 1982, Concourse Hotel, Madison

Wisconsin Radiological Society, Oct 16, 1982 Concourse Hotel, Madison

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SPECIALTY SOCIETY MEETINGS TO BE HELD IN CONJUNCTION WITH SMS ANNUAL MEETING, May 13-15, 1982, Milwaukee

Wisconsin Allergy Society
Wisconsin Orthopaedic Society
Wisconsin Society of Internal Medicine
Wisconsin Society of Pathologists
Wisconsin Society of Physical Medicine and Rehabilitation
Wisconsin Society of Plastic Surgeons
Wisconsin Society for Preventive Medicine
Wisconsin Society of Radiation Oncologists
Wisconsin Surgical Society

APRIL 28-30, 1982: *State of the Art-Radiologic Approaches to the Chest and Abdomen,* Madison. Sponsored by the University of Wisconsin-Extension; Dept of Continuing Medical Education; and University of Wisconsin, School of Medicine, Dept of Surgery. Approved 21 credit hours of Category I AMA and ACR. Info: Sarah Z Aslakson, Continuing Medical Education, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

MAY 5-7, 1982: *Fifth Annual Cardiac Rehabilitation Symposium,* Red Carpet Inn, Milwaukee. Sponsored by Mt Sinai Medical Center, Milwaukee; University of Wisconsin-Extension, Dept of Continuing Medical Education; American Heart Association, and American College of Sports Medicine. Approved 25 credit hours of Category I AMA; AOA Category 2-D, University of Wisconsin Continuing Education Units. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

MAY 23-25, 1982: Wisconsin Chapter, American Academy of Pediatrics, Playboy Club, Lake Geneva.

JUNE 17-23, 1982: *Fifteenth Annual Postgraduate Course in Gynecological Pathology, Cytogenetics and Endocrinology,* Pfister Hotel and Tower, Milwaukee. Sponsored by The Medical

University of Minnesota
CONTINUING MEDICAL EDUCATION
January-July, 1982

Stroke Update ..... Jan 23
Topics in Geriatric Medicine: Drug Therapy Symposium ..... Feb 3-4
Office Management in Ear, Nose & Throat: A Practical, Problem-Oriented Approach ..... Feb 26-27
Cardiopulmonary Medicine: 1982 ..... Mar 4-6
Current Concepts in Perinatal Medicine ..... Mar 11-12
Recurrent Lung Disease in Childhood ..... Mar 26
Psychiatry for Primary Care Physicians ..... Apr 2
Correction of Aphakia (Annual Ophthalmology Course) ..... Apr 19-20
Allergy and Clinical Immunology ..... Apr 29-May 1
Tissue Specific Antigens: An International Conference ..... May 3-5
Human Aging V ..... May 5-6
Medical Directors Spring Meeting ..... May 7
Family Practice Review: Update 1982 ..... May 10-14
Current Concepts in Radiation Therapy ..... May 19-21
Topics and Advances in Pediatrics ..... May 24-25
Biotechnology Symposium ..... May 26-28
Coronary Heart Disease Workshop ..... Jun 2-4
Management of Musculoskeletal Tumors (Annual Orthopaedic Surgery Conference) ..... Jun 9-11
Clinical Hypnosis ..... Jun 11-12
Advances in Vascular Surgery: 46th Annual Surgery Course ..... Jun 14-16
The Disabled Adolescent ..... Jun 29-30
Malnutrition: The Clinician's Role ..... Jul 9-10

Accreditation: All courses are approved for AMA/ACCME Category 1 credit and, as appropriate, by specialty societies.

For advance information and registration, write or call: Continuing Medical Education, University of Minnesota, Box 293 Mayo Memorial Bldg, 420 Delaware St, SE, Minneapolis, MN 55455; ph 612/373-8012. 1-3/82

WISCONSIN (cont).

College of Wisconsin, Milwaukee. Fee: $500 enrollment fee will include 68 selected 35mm slides. Approved 42 credit hours of Category 1 of AMA-PRA and AAFP. Info: Richard F Mattingly, MD, Medical College of Wisconsin, 8700 West Wisconsin Ave, Milwaukee, Wis 53226.

JUNE 16-19, 1982: Annual Scientific Assembly of the Wisconsin Academy of Family Physicians, Radisson Hotel, La Crosse. Approved 20 credit hours Category 1 of AMA-PRA. Info: Robert H Herzog, Wisconsin Academy of Family Physicians, 850 Elm Grove Rd, Elm Grove, Wis 53122; ph 414/784-3656.

JUNE 24-25, 1982: *Obstetrical Events and Neonatal Brain Injury,* Wisconsin Center, Madison. Sponsored by Continuing Medical Education, Health Sciences Unit, University of Wisconsin-Extension and Departments of Family medicine and Practice, Pediatrics, Gynecology and Obstetrics, School of Medicine, University of Wiconsin, Madison, and Madison General Hospital and St Marys Hospital Medical Center. Twelve credit hours, AMA; AOA; CEU's ACOG applied for. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

AUGUST 6-8, 1982: Wisconsin Dermatological Society summer meeting, Lake Geneva, Wis. Info: Robert A McDonald, MD, 1313 Fish Hatchery Rd, Madison, Wis 53715.

SEPTEMBER 9-11, 1982: Wisconsin Society of Internal Medicine and American College of Physicians joint meeting, Holiday Inn Downtown, Green Bay. Info: Kim Marggraf, Wisconsin Society of Internal Medicine, 611 East Wells St, Milwaukee, Wis 53202.

OCTOBER 16, 1982: Wisconsin Radiological Society, Concourse Hotel, Madison.

OTHERS

January-July 1982 (Minnesota): *Continuing Medical Education* programs are listed in a box elsewhere in this section.

IMPAIRED HEALTH CARE PROFESSIONALS: A CHALLENGE TO THE PROFESSIONS

March 5, 1982, Detroit Plaza Hotel, Detroit, Michigan

Sponsored by: The American Society of Law & Medicine, Michigan Association of Osteopathic Physicians, Michigan Hospice Organization, Michigan Hospital Association, Michigan Nurses Association, Michigan Society of Hospital Attorneys, Michigan State Medical Society, State Bar of Michigan—Medicolegal Committee

Faculty: LeClair Bissell, MD; J Kay Felt, JD; Max Weisman, MD; Charlotte B Cloutier, MA, MPA

Fee: $50 for members of a sponsoring organization. $65 for non-members

Continuing education credits Category 1 should be available.

For more information contact: American Society of Law & Medicine, 765 Commonwealth Ave, 16th Floor, Boston, MA 02215; ph 617/262-4990. 1/82

MARCH 1-3, 1982 (Maryland): *NIH Consensus Development Conference on Total Hip Joint Replacement,* at Masur Auditorium, Building 10, National Institutes of Health, Bethesda, MD, sponsored by the National Institute of Arthritis, Diabetes, and Digestive and Kidney Diseases with assistance from the NIH Office for Medical Applications of Research. Administrative info: Mr Peter Murphy, Prospect Associates, 11325 Seven Locks Rd, Suite 220, Potomac, MD 20854 (ph 301/983-0535).

MARCH 1-2, 1982 (Michigan): *6th Annual Winter Pediatric Seminar,* Caribou Lodge, Powderhorn Ski Area, Bessemer, Michigan. Sponsored by Marshfield Clinic and Marshfield Medical Foundation. Approved 8 credit hours of Category I of AMA-PRA and AAFP. Fee: $60. Registration deadline, Feb 22, 1982. Info: Marshfield Clinic's Office of Medical Education, 1000 N Oak Ave, Marshfield, Wis 54449; ph 715/387-5207.
g11-12/81; 1/82

MARCH 5, 1982 (Michigan): *Impaired Health Care Professionals: A Challenge to the Professions.* Details appear in a box elsewhere in this section.

MARCH 15-19, 1982 (Louisiana): Twentieth National Conference on Breast Cancer, Hyatt Regency Hotel, New Orleans, La. Sponsored and arranged by the American College of Radiology; co-sponsored by the American Cancer Society; American Society of Therapeutic Radiologists; College of American Pathologists; The Plastic Surgery Educational Foundation, and The Society for the Study of Breast Disease. Fee: $350. Info: Breast Cancer Conference, American College of Radiology, 6900 Wisconsin Ave, Chevy Chase, MD 20815.

APRIL 4-6, 1982 (Mississippi): *National Conference on Kural Primary Care,* sponsored by National Rural Primary Care Association, at Jackson, MS. This fifth annual meeting provides a singular opportunity for rural health professionals to share insights and discuss problems with peers, while receiving continuing education credit for soundly developed work sessions. Info: National Rural Primary Care Association, Attn: Lane Fisher, Communications Coordinator, Box 1211, Waterville, ME 04901 (ph 207/873-1127).

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NEWS YOU CAN USE continued from following page

For this reason, no legal basis is found for the statement in the WHA General Memo on the retroactive effect and possible liability to a hospital where an audit discloses error in a CME statement. A hospital, its board and medical staff should all be protected by asking the MEB about the registration status of an applicant and repeating the inquiry biennially. Reappointments could be made provisionally subject to confirmation by the Medical Examining Board of each physician's registration status, since that Board cannot answer all inquiries at the time reappointments are traditionally made.

In addition, it should be noted that the Accreditation Manual for Hospitals 1982 under Standard 5 in the section dealing with medical staff requires "participation in continuing medical education programs outside the hospital should also be documented to demonstrate its relevance and the effort made by individual staff members to stay current in their field. . .This information should be incorporated into each staff member's credentials file for evaluation at the time of reappointment/reappraisal."

It can be presumed that many hospitals are already in some way documenting the continuing medical education activities of members of the medical staff, if they indeed are complying with this section of JCAH standards.

We must again state that the *Wisconsin Statutes* do make it presumptive evidence that the person named in a registration is legally registered for the period covered by such registration.

Sincerely,

H.B. Maroney
Assistant Secretary and Corporate Counsel■

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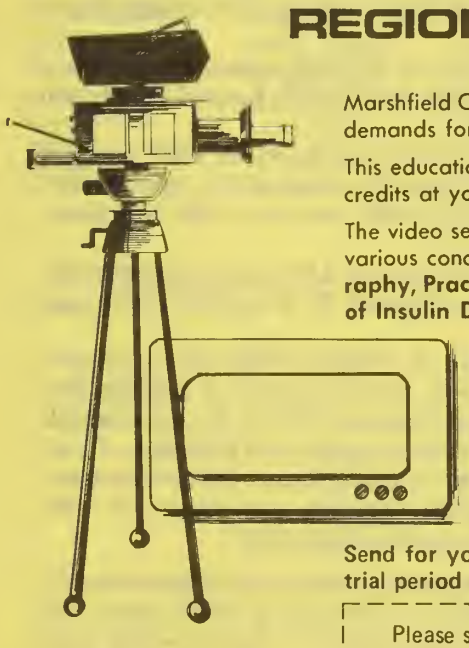
REGIONAL VIDEO NETWORK



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MEB NEW POLICY—CME REQUIREMENTS

The following letter was prepared for use in responding to inquiries about the new policy of the Medical Examining Board concerning continuing medical education requirements.

***

Dear . . . . . .

The Society has received several questions concerning the Medical Examining Board's new policy of doing only random audits of the Wisconsin continuing medical education requirement for valid registration, and hence a valid license to practice medicine.

The Society's general counsel, Robert B L Murphy, Esq, has been asked to research this question and has reached several conclusions, which follow:

"First, neither a Wisconsin hospital, nor its medical staff, has a legal obligation to verify independently the accuracy of the CME statement required by statute and rule to be made biennially by a physician licensed and registered in Wisconsin. We include medical staffs because they are so significant a part of the total process of determining professional qualifications and performance of medical staff members.

"Second, no hospital or medical staff should incur legal liability by their reliance on state licensure and registration without independent verification by such hospital or staff. Each physician who makes an original application for staff privileges, or seeks reappointment with such privileges, could be asked to state in writing that his or her Wisconsin license and certificate of registration were both in good standing, and could be required further as a continuing condition of staff privileges to notify the hospital in writing if there were any change in either respect.

"Third, if the MEB, which is charged by law with the administration of CME statements, believes a random audit will suffice, we are unable to imagine that liability could result unless hospital boards and medical staffs devised machinery more demanding than the law itself.

"Fourth, hospital and medical staffs have no reason to be more exercised over the revised CME policy of the MEB than the malpractice carriers. We have not contacted all carriers, but inquired of a representative cross section. We found their spokesmen did not regard the revised MEB rules on CME compliance as a significant or likely source of potential legal liability.

"Fifth, there is a growing concept that the medical and non-medical parts of a hospital organization are part of *one* functional unit. See *Johnson v Misericordia Community Hospital,* 97 Wis 2d 521 (1980) page 532, Note 4.

"Sixth, more important than assuming the essentially clerical task of verifying CME reports, hospital boards, administration and medical staffs should become more efficient, tighter knit units in fulfilling their basic responsibilities for staff appointments, reappointments and performance. This is the unmistakable direction of hospital literature and court opinions. High standards of investigation, the limitation of staff privileges to what is justified by the training, experience and judgment of the applicant, effective monitoring of the performance of each staff member, followed by the increase, reduction, continuation, or withdrawal of staff privileges, are all part of the public accountability of a community hospital."

It is the conclusion of Mr Murphy, that the last paragraph of WHA general Memo 65-81 of September 25, 1981, which states that, "the 'random audit' approach of the MEB to verification of CME credits, will place additional responsibilities on hospitals," is not necessarily a correct assumption. Section 448.07 (1)(c) of the *Wisconsin Statutes* provides:

> "Every registration made as provided in this section shall be presumptive evidence in all courts and *other places* that *the person named therein is legally registered for the period covered by such registration,* and shall be deemed to fulfill any statutory requirement for renewal of license or certificate." (italicizing supplied)

continued on preceding page

Bactrim™
(trimethoprim and sulfamethoxazole)
succeeds

Bactrim is useful for the following infections when due to susceptible strains of indicated organisms (see indications section in summary of product information):

Expanding its usefulness in antimicrobial therapy

in recurrent UTI...
a continuing record of high clinical effectiveness against common uropathogens

in acute otitis media in children...
effective against both major otic pathogens...with *b.i.d.* convenience

in acute exacerbations of chronic bronchitis in adults...
clears the sputum and lowers its volume...on *b.i.d.* dosage

in shigellosis...
faster relief of diarrhea than with ampicillin[2]

Bafora prascribing, plaasa consult complata product information, a summary of which follows:

Indications and Usaga: For tha traatmant of urinary tract infactions dua to auscaptibla strains of tha following organiams: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* it is racommandad that initial aplaodas of uncomplicatad urinary tract infactions ba traatad with a aingla affactiva antibactarial agant rathar than tha combination. *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

For acuta otitis madia in childran dua to suscaptibla strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* whan in physician's judgmant it offars an advantaga ovar othar antimicrobials. Limitad clinical information prasantly availabla on affactivanass of traatmant of otitis madia with Bactrim whan infaction is dua to ampicillin-rasistant *Haemophilus influenzae.* To date, there ara limitad data on the safaty of rapaated usa of Bactrim in childran undar two yaars of age. Bactrim is not indicatad for prophylactic or prolonged administration in otitis madia at any aga.

For acuta axacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgmant it offars an advantaga ovar a singla antimicrobial agent.

For enteritis dua to suscaptibla strains of *Shigella flexneri* and *Shigella sonnei* whan antibactarial tharapy is indicatad.

Also for the traatment of documentad *Pneumocystis carinii* pnaumonitis. To date, this drug has bean testad only in patients 9 months to 16 years of age who were immunosupprassed by cancer therapy.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus, infants less than 2 months of age.

Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: *General:* Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients, cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosaga: Not racommanded for infants less than two months of age.

URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:

Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.

Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.

For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.

ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:
Usual adult dosage. 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days.

PNEUMOCYSTIS CARINII PNEUMONITIS:
Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplad: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100; Prescription Paks of 20 and 28. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40. *Pediatric Suspension,* containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); cherry-flavored—bottles of 100 ml and 16 oz (1 pint). *Suspension,* containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).

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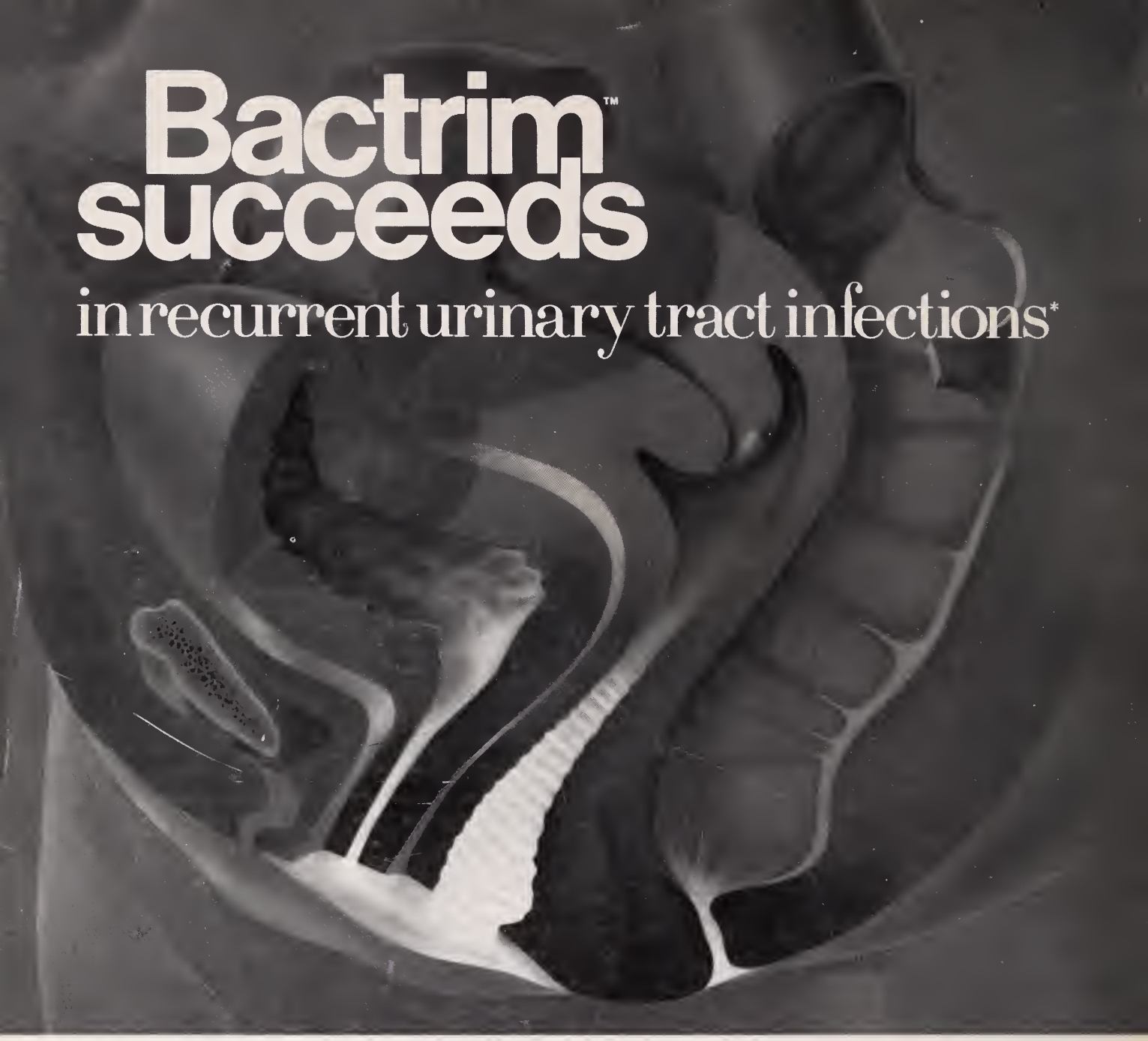

Bactrim™ succeeds

in recurrent urinary tract infections*

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Bactrim continues to demonstrate high clinical effectiveness in recurrent urinary tract infections. Bactrim reaches effective levels in urine, serum, and renal tissue[1]... the trimethoprim component diffuses into vaginal secretions in bactericidal concentrations[1]... and in the fecal flora, Bactrim effectively suppresses Enterobacteriaceae[1,2] with little resulting emergence of resistant organisms.

1. Rubin RH, Swartz MN: *N Engl J Med* 303:426-432, Aug 21, 1980. **2.** Data on file, Medical Department, Hoffmann-La Roche Inc.

Bactrim™ DS
160 mg trimethoprim and 800 mg sulfamethoxazole
DOUBLE STRENGTH TABLETS

maximizes results with B.I.D. convenience

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*due to susceptible strains of indicated organisms

Please see previous page for summary of product information.

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VOL. 81 #2

FEBRUARY 1982

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*Present as 230.6 mg, 345.9 mg, and 691.8 mg of the calcium salt of fenoprofen dihydrate equivalent to 200 mg, 300 mg, and 600 mg fenoprofen respectively

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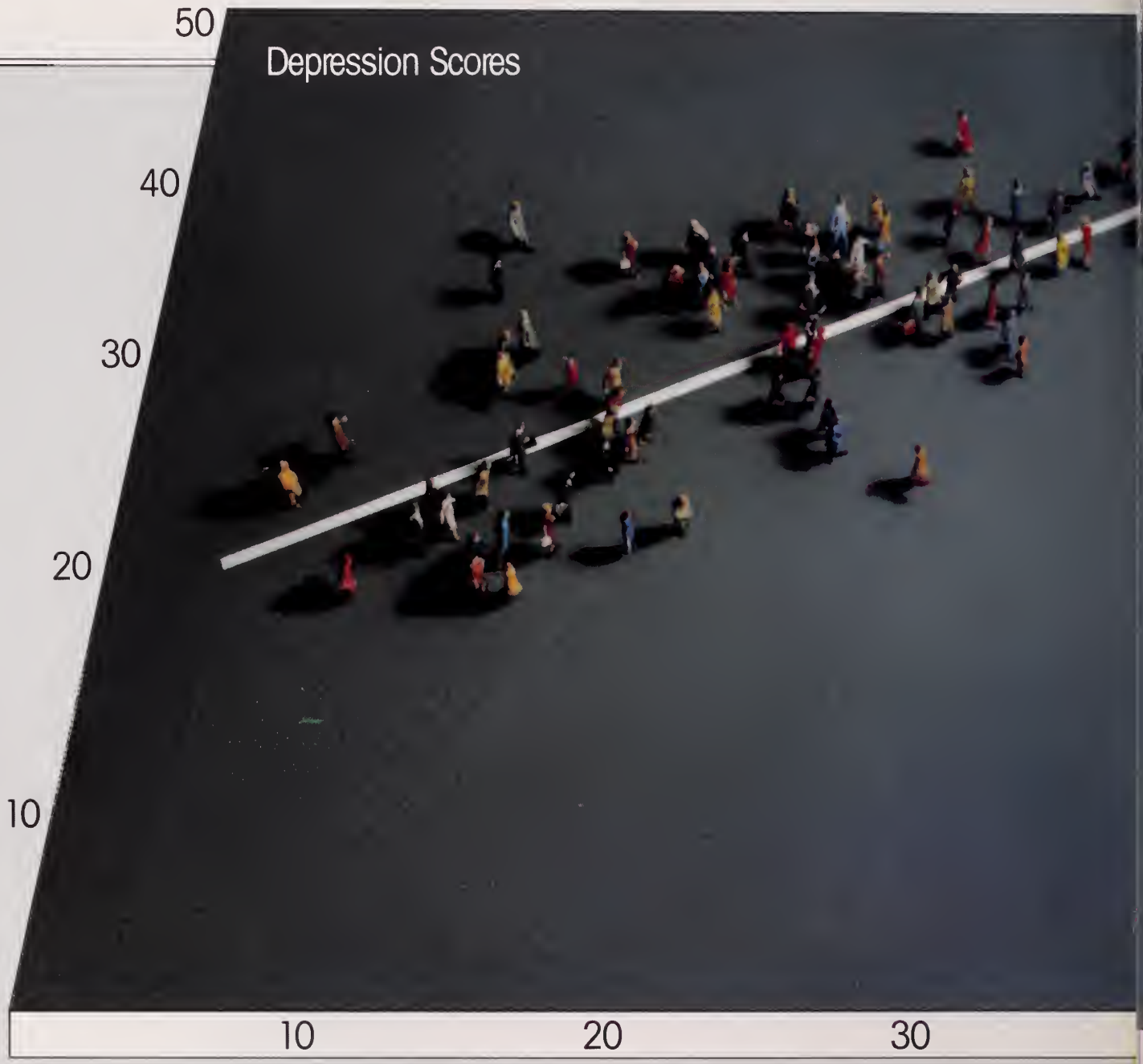
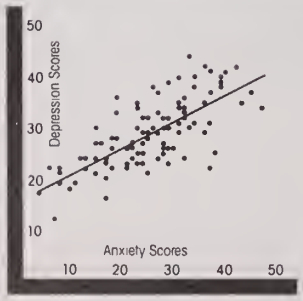




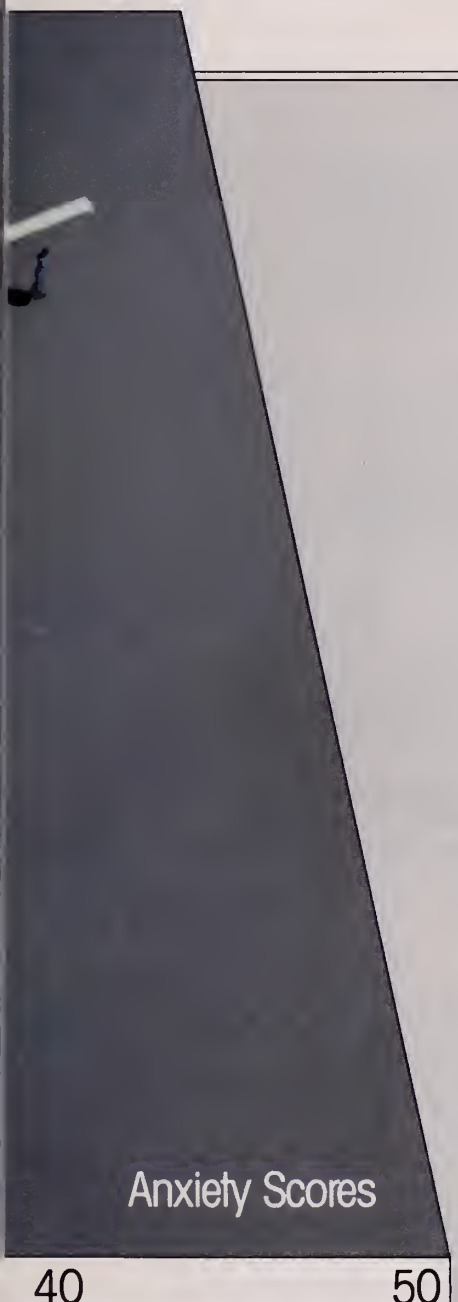
Clear correlation between anxiety and depression[3]

The above graph illustrates a relationship between anxiety and depression, indicating that patients seldom present with anxiety or depression alone; more often they have both in varying degrees. Data based on a sampling of 100 outpatients (64 male; 36 female) seen at a general psychiatric clinic.

[3]Adapted from Claghorn, J. The anxiety-depression syndrome. *Psychosomatics 11*:438-441, Sept-Oct 1970.

ROCHE

DEPRESSED PATIENTS WHO ARE ALSO ANXIOUS[1,2]



Most depressed patients are also anxious...

Some authors estimate that 70% of all nonpsychotic patients with symptoms of depression have concomitant symptoms of anxiety.[1,2] One author found a distinct correlation between anxiety and depression scores in 100 nonpsychotic outpatients administered the Minnesota Multiphasic Personality Inventory in a general psychiatric clinic.[3] As depression scores increased, so did anxiety scores. No attempt was made to select patients other than to exclude psychotics.

but not psychotic

The logic of treating both components of anxious depression is clear. Antipsychotics, like the phenothiazines, however, carry a well-documented risk of tardive dyskinesia.[4] Because of this, an APA Task Force recently recommended the judicious use of phenothiazines in cases other than chronic psychosis or the use of alternative treatments.

A better way to give relief

Limbitrol combines the specific anxiolytic action of Librium® (chlordiazepoxide HCl/Roche)—a benzodiazepine with a long history of safe use—with the antidepressant action of amitriptyline, a tricyclic of established clinical efficacy. In comparison to phenothiazines, Limbitrol and its components have rarely been associated with tardive dyskinesia or other extrapyramidal side effects. And in terms of rapid response and patient compliance, Limbitrol appears to be superior to amitriptyline alone. Controlled multiclinic studies showed Limbitrol relieved more symptoms more rapidly than did amitriptyline.[5] Despite a higher incidence of drowsiness, the dropout rate due to side effects was lower with Limbitrol. (See adverse reactions section in summary of product information on next page. As with any CNS-acting agent, patients should be cautioned about driving or using dangerous machines while on therapy with Limbitrol.)

References: 1. Rickels K: Drug treatment of anxiety, in *Psychopharmacology in the Practice of Medicine,* ed. Jarvik ME. New York, Appleton-Century-Crafts, 1977, p. 316. **2.** Schatzberg AF, Cole JO: Benzodiazepines in depressive disorders. *Arch Gen Psychiatry 35:*1359-1365, 1978. **3.** Clagharn J: The anxiety-depression syndrome. *Psychosomatics 11:*438-441, 1970. **4.** The Task Force on Late Neuralogical Effects of Antipsychatic Drugs: Tordive dyskinesia, summary of a task farce repart of the American Psychiatric Assaciatian. *Am J Psychiatry 137:*1163-1172, 1980. **5.** Feighner JP *et al:* A placeba-cantralled multicenter trial of Limbitral versus its components (amitriptyline and chlardiazepaxide) in the symptamatic treatment of depressive illness. *Psychapharmacalagy 61:*217-225, 1979.

In moderate depression and anxiety

Limbitrol® IV

Tablets 5-12.5 each cantoining 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)

Tablets 10-25 each cantaining 10 mg chlardiazepaxide and 25 mg amitriptyline (as the hydrachlaride salt)

Relief without a phenothiazine

Please see summary of product information on next page.

LIMBITROL® TABLETS Tranquilizer–Antidepressant
Before prescribing, please consult complete product information, a summary of which follows:
Indications: Relief of moderate to severe depression associated with moderate to severe anxiety
Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use, then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.
Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).
***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline, symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).
Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12.
In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.
Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.
The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:
Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.
Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.
Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.
Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilation of urinary tract.
Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.
Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.
Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.
Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels.
Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.
Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.
Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly. Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased to six tablets or decreased to two tablets daily as required. Limbitrol 5-12.5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses.
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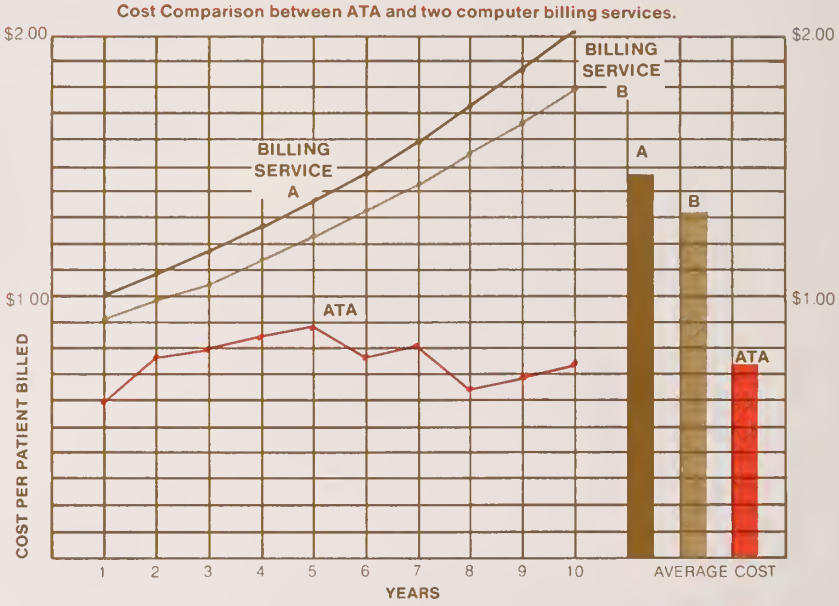

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Medical computer systems

President's Page

ALBERT J MOTZEL JR, MD

Quality and cost-effectiveness—not at odds

ARE QUALITY AND COST at odds in the distribution of medical care as some would have us believe? Is quality medical care a legitimate excuse for exorbitant costs as others suggest in justifying the cost of care?

Without belaboring the cost increases associated with the loss of purchasing power of the dollar let us look at medical care in 1982 and beyond from the point of view of quality. With quality in mind let us consider the implications of the above questions.

There is no doubt that a level of care could be offered today in which individuals trained for short periods could administer "protocols" on the basis of specific symptoms and physical findings. For those problems which are simple and uncomplicated this would seemingly constitute quality and potentially economical care. Unfortunately most problems are not so simple, and of those that are many have ramifications that can seriously affect future health and, therefore, both quality of life and future cost.

No doubt this risk can be reduced with supervision by a competent and properly motivated physician, but in the area of diagnosis and treatment the ultimate quality may be proportional to the duplication of time. If this is true, then quality is ultimately based on practitioners fully educated in the basic scientific underpinning of modern medical care as well as the anatomic and physiologic interrelationships between systems—practitioners qualified to recognize and respond to individual variations and complications. What then are the implications of "quality" at this level in 1982?

Because today's medical graduates have had greater opportunity for broader clinical experience in medical school than those graduates of the past, we have seen abandonment of the "rotating internship" and its replacement with the "PG-I" position. Nevertheless we rarely see a physician enter practice today without at least three years of postgraduate training. If this time is spent effectively, it must concentrate the knowledge and experience previously acquired during some years of practice through exposure to a variety of common and complicated cases and to knowledgable and competent teachers in the field of primary emphasis. Additionally this period of training must instill a lifelong habit of study and true dedication to excellence in patient care.

This process of training brings practitioners to the point of practicing independently. They come with a depth of background knowledge and an additional refinement of knowledge and skill in dissimilar fields. Because virtually all physicians emerge from this system today, there is little opportunity or justification for differing in one's practice pattern or area of emphasis much beyond that in which training has taken place. There is, however, much room left for expansion of knowledge and experience in an ever-deepening understanding of his or her own area of expertise.

It is in this context that quality and cost-effectiveness have the potential to become complementary. Ultimately it is the knowledge and experience of the individual physician practicing within his or her area of real expertise that will result in excellent and cost-effective care. The recognition of real or likely problems underlying a given set of symptoms and circumstances with the undelayed performance of the most appropriate diagnostic and confirmatory studies, followed by the early institution of the most effective treatment, is the essence of both quality and cost-effectiveness. Similarly the most adept performance of the correct diagnostic or therapeutic procedure by a practitioner well trained and able to recognize and properly treat those complications inherent in these procedures or in susceptible individuals can purvey the highest quality and most economical care. Quality suffers most at the hands of the practitioners who are least adept at recognizing the likely nature of a problem. Therefore, they must proceed too often through the ordering of numerous studies to guide them to the correct diagnosis. Even worse, they may not recognize serious symptoms and signs for what they portend and neglects a problem or complication at a stage in

continued next page

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which the solution might have been simple and brief only to have a complicated, prolonged, costly, or even disastrous outcome result.

None of this suggests that a training program in any particular specialty has a monopoly on quality or that good perceptive and effective physicians are not found in all fields of practice. However, in an era in which physicians are likely to be in abundant supply, with expertise in all fields available without undue inconvenience to virtually all patients, and increasing review of quality (including those encounters incurring inordinately high cost), it will behoove all programs to educate their residents well in those areas in which their practices will be concentrated and to stress that all physicians are to practice within the limits of their training.

In conclusion it is the physician utilizing his breadth of knowledge, but proceeding in the specific area in which he or she has acquired special expertise, to render the best and most efficient care in each case that will produce the quality and economy so necessary now and in the future. It is delay in or failure of diagnosis, unnecessary complications, and duplication which add most to the unjustified cost of care. Quality and cost of medical care are not at odds, and quality in itself does not generate exorbitant cost. ■

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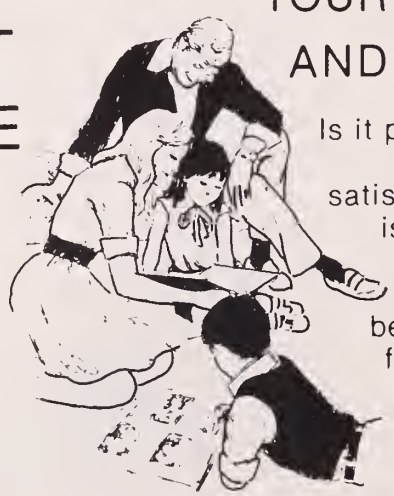

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Editorials WAYNE J BOULANGER, MD, *Editorial Director*

Official positions of the Society will be expressly identified as such; all others are views of the writer and not necessarily those of the Society.

The "sentinel effect"

THE WISCONSIN State Legislature has required that the Department of Health and Social Services (DHSS) evaluate the effects of its Second Surgical Opinion Program for Medicaid and report its findings to the Joint Committee on Finance and the appropriate committees in each House not later than January 1, 1982. In December 1981 the Department made its report after providing the Medical Society with a draft for review.

The report covers the period from the Second Opinion Program's implementation in February 1981 through September 1981, using data based on claims paid by EDS Federal Insurance. It took into account only partially the start-up and tail-lag periods.

Massive reductions in surgery are claimed, for instance a 34.7% reduction in cholecystectomies, 38.4% drop in hemorrhoidectomies, 34.3% drop in hysterectomies, a 49.7% drop in varicose veins, and a 53.4% drop in D&Cs.

(This in spite of the fact that the rate of disconfirming second opinion was only 6.9%.)

The Department further postulates a net savings of $2.8 million, and states that 90% of the reduction in surgery is due to what it calls the "sentinel effect."

The "sentinel effect" is the deterrent effect of the mere existence of a second opinion program. In other words, surgeons are more circumspect in recommending operations if they know that another surgeon will be asked to judge the worth of their proposals.

There are many aspects of the report which are open to attack, especially with regard to the data used in arriving at the rather optimistic conclusions. Perhaps the greatest flaw in the report is simply that the program hasn't been in full swing long enough to permit detection of any sort of trend. But the most irresponsible conclusion is the bald statement that 90% of the drop in surgery is due to the "sentinel effect." There is absolutely no element of the second opinion program which is designed to assess the "sentinel effect" in the first place. To assume that a reduction in the number of operations actually performed is for the most part due to the fact that Big Brother is watching is to impugn the character of a great number of Wisconsin surgeons. To make such a statement without proof is not worthy behavior of a governmental agency.

Despite these deficiencies the Medical Society is asking the DHSS and the Legislature (as is DHSS) to continue the program for at least a total of two years from inception to get an adequate trial period for data, and at the same time to improve its data gathering technics and the methodology for evaluation. —WJB

Liability update

A NEW ALLEGATION of malpractice is filed with the Wisconsin Patients Compensation Panels each and every day. There are currently 342 pending cases, 80% of which will be processed through formal panels.

Of all filed cases 35% go to a panel hearing; 60% are settled prior to hearing. Of those that have gone to a hearing, claimants have won 31% and physicians and hospitals 68%. No information is available on those settled prior to hearing because there is no requirement for reporting their outcome.

The mean time from filing a complaint of malpractice to disposal is 230 days. The law requires their settlement in 120 days. Even though the caseload is lagging, eight months from filing to settlement is a huge improvement over the 3-5 year trial tail that Wisconsin experienced prior to 1976.

The slowdown, however, has two major causes. One, the panels' administrative agency has a rapidly growing caseload, but state rules frustrate its ability to obtain additional clerical help even though it has $2 million in reserves paid entirely by physicians and hospitals. This bureaucratic-legislative stupidity is causing undue pain, suffering, and expense to both physicians and consumers.

Two, a shortage of available defense attorneys appears to have a major impact on the speed with which cases can be moved through the panels. There are only three major liability insurance carriers in the state. Each has its own small cadre of "top notch" defense lawyers, and each wants every case handled by its best. This causes obvious delays in scheduling. The Bar of Wisconsin has some obligation to seek elimination of this problem, again in the interest of economics and humane concern. —ERT■

Letters

The Editors would like to encourage physicians to contribute to the LETTERS section where they can ventilate their frustrations as well as opinions. This feature is intended to be lively and spirited as well as informative and educational. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address correspondence to: The Editor, Wisconsin Medical Journal, Box 1109, Madison, Wis 53701.

Inappropriate hospitalization

TO THE HONORABLE WILLIAM PROXMIRE (US Senate): I enclose a column from the December 1981 *Wisconsin Medical Journal* ("Lies" [editorial], page 9) which nicely illustrates the scrutiny that the private sector is bringing to bear on inappropriate hospitalization. I fully support and encourage this type of scrutiny, and in fact we here are exerting similar pressure to reduce lengths and frequency of hospitalization of our patients. This effort of course is being strongly stimulated by our friends in Washington, in an effort to curtail rising health care costs.

Why then can't they direct similar energy toward promoting greater efficiency in our ludicrously lax and expensive VA Hospital program? I have enclosed a discharge summary from the . . .VA Hospital which I recently received on a patient of mine. He was admitted for two and a half days in June simply for the purpose of having a physical examination, a chest x-ray, EKG, and a blood count. I can see absolutely no excuse for not prohibiting that type of wasteful expenditure of resources, or requiring the same degree of justification of it as we do in the private sector. This "veteran" (as they so charmingly refer to him repeatedly in the history) was not in the least bit sick but was admitted solely for a "routine annual comprehensive physical examination" which could have been accomplished in about an hour and a half as an outpatient.

I urge your support of the proposition that *all* hospitals public or private be subject to the same utilization review principles.

Nelson A Moffat, MD
President, Marshfield Clinic
Marshfield, Wisconsin

Nutrition issue

TO FREDERICK STARE, PHD, MD (Harvard Medical School): I must commend you on the excellent historical reviews which you helped plan and part of which you wrote for the October 1981 *Wisconsin Medical Journal.* The papers are very interesting and well done. Although this is "old stuff" to you and the other authors, Wisconsin's development of nutritional sciences is largely unknown by most physicians and nutritionists. I put the entire issue on my "Highly Recommended Reading" list for my ADA approved, continuing education telephone conferences for Wisconsin dietitians.

Ruth S Dickie, RD
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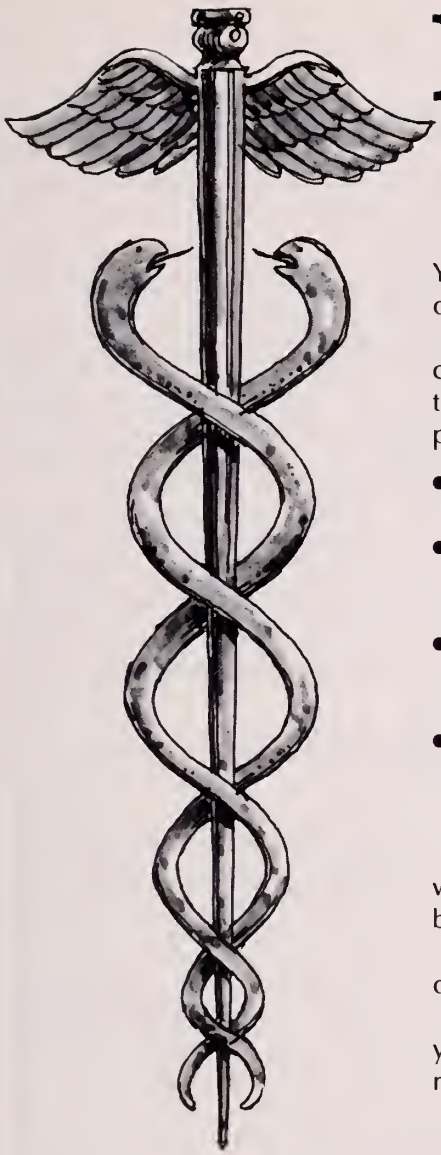

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MEMBERSHIP FACTS

ARE YOU A MEMBER of the State Medical Society of Wisconsin, or do you know someone who isn't? Whether you're just starting medical school, maintain a full-time practice, or are retired, SMS has a membership classification to fit your individual needs. Furthermore, in light of a recent change in membership policy, physicians may join their county and state societies and the AMA or just their county and state societies; however, AMA membership is encouraged. Dues for regular membership are $410 for SMS, $285 for AMA, and county society dues vary. A more detailed listing of SMS membership classifications and their corresponding dues follows:

State Medical Society of Wisconsin

DESCRIPTION OF DUES CLASSIFICATION CODES

Regular: Member in active practice. Some are regular members that have reduced SMS and/or AMA dues because they are new practitioners (first year or two out of residency).

Resident: Physician who at January 1 of dues year is in an approved training program as a hospital resident or research fellow who is licensed to practice medicine and surgery in Wisconsin.

Military Service: Members who are serving in the U.S. armed forces (generally not to exceed five years).

Associate: Member whose dues are waived because of illness or financial hardship. This classification is temporary and is reviewed on an annual basis.

Life: Member who has held membership in a state medical society for 50 years or is a Past President of the State Medical Society of Wisconsin.

Honorary: Member who was named by the Board of Directors in recognition of long and distinguished service to the cause of medicine.

Retired: Member who has completely retired from practice (works less than 240 hours per year). All dues are waived unless county society indicates they wish to charge county dues.

Part-time Practice: Physician, regardless of age, who practices 1,000 hours or less during the calendar year but does not qualify for retired membership.

Over Age 70: Member in active practice who is over 70 years of age.

Candidate: Member attending a medical school in Wisconsin or fulfilling a postgraduate obligation prior to eligibility for licensure.

Scientific Fellow: Member who is engaged in teaching one or more of the basic sciences at an accredited college or university, and not holding the degree of Doctor of Medicine or Osteopathy.

Emeritus: Retired members who have chosen not to renew their license.

1982 DUES AMOUNTS FOR THESE CLASSIFICATIONS

	SMS	AMA	COUNTY
Regular	$410	$285	Normal County Dues
Resident	41	35	Varies
Military Service	-0-	285 or 35	-0-
Associate	-0-	-0-	-0-
Life	-0-	-0-	-0-
Honorary	-0-	-0-	-0-
Retired	-0-	-0- *	-0-
Part-time Practice	205	285 *	Normal County Dues
Over Age 70	205	-0- *	Normal County Dues
Scientific Fellow	-0-	-0-	
Emeritus	-0-	-0-	
Candidate—			
Freshman Year Medical Student	-0-	15	Varies
Sophomore and Succeeding Medical Student Years	10	15	Varies
Postgraduate—One	10	35	Varies

*Due to recent policy changes by the AMA, future exemptions from AMA dues will be given to those physicians who are over 70 years of age *and* are retired from practice or practice 1000 hours or less a year.

1982 Dues must be paid in full by May 15

Physicians are reminded that the newly revised Constituion and Bylaws, as adopted by the 1981 House of Delegates and printed in the June 1981 BLUE BOOK issue, state that "any member whose current year's dues have not been received by the secretary of this Society by May 15 shall be deemed in arrears and his name shall be removed from the membership rolls of his county society and this Society until such time as full dues for the current year have been received."

—Membership Department

SMS LEADERSHIP CONFERENCE 1981— PAGE 1

Issues that may shape your future

The State Medical Society of Wisconsin took a look at its future and the future of medical practice at the Brookfield Marriott November 6 and 7 at a Leadership Conference for state, county, and specialty society representatives and medical auxilians. The purpose of the meeting was to have medical leaders address issues that the SMS Board of Directors perceived to be the primary concerns for the next two to three years. Physician leaders from throughout the state were brought together to exchange ideas, concerns, and thoughts on how organized medicine might deal with these issues and what priorities it might attach to them. What follows is a summary of each of the panels presented during the course of the meeting.

I. SMS Services, Inc.—What it can do for you

SMS Services, Inc was formed by the SMS House of Delegates in 1978 to expand the number and quality of "tangible" benefits available to SMS members, according to William P Crowley, MD, Madison, President of SMS Services, Inc. Designed under the philosophy that "those persons who take advantage of the services should pay the freight," SMS Services, Inc today offers a wide range of group insurance plans, discount and rental programs, as well as functioning as a licensed insurance agency for its members. "The Board of Directors of SMS Services was especially pleased this past year to see the corporation operating 'in the black'—something that was not anticipated to occur for several years yet," he noted. "If this good expcrience continues, SMS can look forward to receiving cash dividends on the stock it owns in SMS Services, Inc."

Outlining the non-insurance programs of SMS Services, Inc was its Executive Vice President Lee Johnson. Johnson stated that SMS Services endorses several programs such as a debt collection service operated by IC Systems, a furniture discount program (one doctor *saved* $5,000 on a single purchase), a book discount program (it sells $4,000 worth of books each month), and auto leasing and rental programs. In regard to the debt collection service, he said that the company is careful to preserve the doctor-patient relationship in this uncomfortable area of debt collection and that in the past year, SMS members have *saved* more than $77,000 on a total of $1,600,000 in "uncollectable" debts as a result of this service.

Johnson also explained that SMS Services has sponsored financial planning seminars for physicians, operates a print shop for SMS and MD use, and is the broker for the uniform claim form. Using the uniform claim form, which is available through SMS Services at its special rates, doctors' offices can reduce their administrative costs, he said.

Much activity in recent years has taken place in the insurance activity of SMS Services. Don Peterson, Service Programs Manager, noted just how important insurance is to the physician's office by pointing out that three to five percent of the gross bookings of an MD practice is spent on business and personal insurance. Group plans, such as those offered through SMS Services, Inc, have the advantage, he said, in offering better benefits at lower rates.

SMS Services, Inc has updated its health protection and group term insurance plans and is in the process of updating disability and overhead expense plans to make sure they represent the best insurance buys for the membership.

"The 5,700 physicians in Wisconsin have their insurances scattered with insurance agents all over the state, very often spreading policies among several agents," Peterson said. To rectify the disadvantages of this approach, SMS Services has become a licensed insurance agency and has a goal to consolidate all the insurance business for MD members under one agency.

"Consolidation will bring with it several advantages," Peterson said, "namely lower costs through mass purchasing power, more power with insurance companies in negotiating policies, and more control over the insurance programs themselves."

This will all take an effective marketing and distribution program, Peterson said. A marketing staff under the direct supervision of SMS Services, Inc has been developed for this purpose.

II. Why doctors must do business with business and labor

"Organized medicine has not yet fully accepted the idea that we have a cost problem in health care," Russell Lewis, MD, Marshfield and immediate past president of SMS told the physician group. "While the quality and accessibility of care has increased in recent years, we've not done a good job on the cost of health care which now represents 9 to 10% of the GNP."

"Business now is interested in the health care cost dilemma as it finds itself paying out 20 to 30% more in worker compensation, disability and health insurance premiums for employees each year," Doctor Lewis explained. Coalitions have sprung up between business and physician leadership in 39 communities in the United States to deal with the problem, he noted.

The State Medical Society has begun a series of meetings with business leaders around the state this past year to discuss the rising cost of health care and what could be done about it. As an example, last March SMS leaders met with the Kohler Company, one manufacturer that is devoting substantial attention to the problem. Kenneth Conger, Vice President of Administration at the Kohler Company, was present November 6 to discuss his company's perspective on the problem.

Conger said his company has witnessed nearly a 50% increase in health insurance premiums (not including dental, worker compensation or disability costs) for its employees over the last two years. This dramatic increase has forced Kohler, like other major employers, to begin to look carefully at health care costs and try to contain them, he said.

"The major factor in costs is hospitals," Conger said, "there are too many, with excess capacity and 'we'—business—pay the bill." He said hospitals should begin to operate like corporations; *ie,* keep their costs to a minimum.

In regard to physicians, Conger said that business doesn't have a major concern with what physicians charge for their services, but it does ask that physicians help control utilization of hospital services.

Conger believes part of the solution might be found in co-payments. "If the patient pays 20% of the bill, he or she will more likely shop around for the least expensive hospital and the physician who is most efficient in his/her practice," he said. He admitted that business must accept a large part of the blame for health care costs, as they negotiated full insurance benefits throughout the 1960s without realizing the potential for dramatic cost increases. He further admitted that it will be extremely hard for business to reduce those benefits or institute co-payment provisions in union contracts without forcing a strike. "But if it takes a strike to control costs, business may have to weather a strike," he said.

"If we don't stop building hospitals and stop duplicating services, business will be forced to begin looking at the Health Maintenance Organization concept and other forced competition tools," Conger said.

Looking ahead, both Doctor Lewis and Mr Conger underscored the necessity of (1) business-labor-physician coalitions being formed on the local level to deal with the cost problem. "We have to start working with industry and labor," Doctor Lewis said, "or we will find ourselves working alone or for the government;" (2) getting the employee back into the act; (3) working with hospitals to control utilization and coordinate services to reduce duplication, and (4) starting communications with patients early in their treatment for worker compensation and disability cases.

III. Health planning if the Feds pull out

"Significant changes in funding and government support are on the horizon for health planning," Guenther Pohlmann, MD, Milwaukee, forecasted during a leadership panel dealing with the future of health planning November 6.

The chairman of the SMS Commission on Health Planning said that "more than ever, the government is questioning the effectiveness of health planning and what, if any, mechanisms should replace it."

Doctor Pohlmann summarized a brief history of health planning by noting that the government's objectives in planning have always been narrow and nearsighted. Originally, planning had been designed to increase the availability of health services. "It was only later in the 1970s that planning became overshadowed with regulatory objectives, the result being laws like Federal Law 93-641."

"Medicine today is still a cottage industry, consisting of mainly small, independent units," Doctor Pohlmann said. He urged that physicians

start coordinating these units, and that perhaps the "coalition" approach to health care costs discussed earlier, might also be applied to health planning as an alternative to regulation.

SMS health planning coordinator Neal Neuberger gave attendees a rundown of the latest developments in health planning—including existing laws and the prospect for financial support.

"Health planning is currently slated for phase-out by the Reagan administration in 1982-83," Neuberger told the group. "In addition, there is a bill pending in Congress (HR 4554) which would repeal the Federal Health Planning Laws (PL 93-641 and PL 96-79) which together constitute the federal statutory authority for health planning. The SMS Health Planning Commission supports this bill and has recommended to Wisconsin's Congressional delegation that federal funds be made available in block grants to states for locally-based voluntary health planning."

Neuberger said that while HSAs have been successful in recognizing local needs, much of the problem lies in centralization of health planning with the state. The Governor's Health Policy Council has recommended to the Legislature and the Governor that state and local funds be used to maintain a voluntary health planning system in Wisconsin.

"In the next few months the acronym you will all be hearing about is referred to as 1536," Neuberger said. "This recently enacted provision of the Health Planning Amendments allows states to petition the federal government to eliminate Health Systems Agencies." Several states, including Ohio, have given serious consideration to or have already eliminated their planning programs.

"Meanwhile, the Reagan administration's federal block grant program has shifted the major focus of the administration for 25 former "categorical" programs from the feds to the states," Neuberger said. (Proposed are four health and three social service block grants which would allow states to spend the money within each block without as many restrictions.) "Congressional debate continues over the actual appropriation levels for the blocks, and on the state level it appears that it will be primarily up to the Governor and Secretary Percy to decide how the health and social service block grants will be spent," he said.

"PSROs are experiencing severe budget cutbacks under Reagan with Congress authorizing $99 million for PSROs for 1982, but the administration is proposing between $60-70 million," he said. The next round of PSRO phase outs will occur after a new "evaluation" takes place, Neuberger said. "And if current rankings are used, FMCE in southeastern Wisconsin will probably be terminated."

The Reagan administration has taken a "go-slow" approach in developing its own "pro-competition" bill, according to Neuberger. The administration has a special task force studying the issue and that task force report is not expected until well after several other proposals have received considerable congressional attention.

"On the Wisconsin scene, we have had some success in changing the Certificate-of-Need law," Neuberger said. He cited the repeal of the state decertification authority and the SMS negotiated settlement on the hospital construction moratorium—which raised the maximum threshold from $250,000 to $1 million for hospital construction.

"Indeed, the very architects of the Wisconsin regulatory approach to health planning such as Senator Paul Offner and Professor Ralph Andreano now have admitted that regulatory mechanism has failed," Neuberger stated.

George Handy, MD, Madison, medical director for Cuna Mutual Insurance Group, presented his proposal for developing a more appropriate Health Planning System in Wisconsin.

The former state health officer told physicians that they should support a strong public health system which integrates with the health planning effort in order to reduce health care costs. "The health of the public in the last ten years hasn't really improved except through areas of public health," Doctor Handy said. "Costs, on the other hand, have increased substantially."

Key elements of Doctor Handy's proposal for health planning include:

- Health planning councils should be advisory to government and the Legislature regarding expenditures of health resources.
- A regional health planning system should be created for distribution of resources going into the counties.
- The Health Policy Council should be advisory to the Secretary of the Dept of Health and Social Services, the Governor and the Legislature.
- Locally, Health Systems Agencies should assist governmental bodies which provide service.
- Counties should give consideration to the consolidation of their health functions with a more direct tie-in to the local planning agencies.

IV. Is another malpractice crisis coming to Wisconsin?

The ever-changing malpractice scene was discussed by a panel moderated by Russell A Quirk, MD, Racine, Chairman of the SMS Medical Liability Committee. Doctor Quirk pointed out that the Wisconsin Health Care Liability Insurance Plan has done a lot to help stabilize the professional liability situation in Wisconsin.

Created as a result of the crisis in the mid 1970s WHCLIP has 60% of the Wisconsin physician population insured under it. Additionally, rates have been stable or decreased each year and a $30 million reserve has been accumulated. On the other hand, Doctor Quirk noted that the "umbrella fund" has seen "progressive premium increases over the years due to the severity of the claims." He stressed that the Patients Compensation Panel System is truly a "unique form of justice" where the defendant's case is heard by two physicians, two consumers, and one attorney, all of whom can ask questions directly and immediately of every witness. "While it is the duty of every physician to serve on the panels," he said, "physicians have unfortunately been reticent to serve on them."

The issue of tax status, new legislation, panel service, and loss prevention were covered by SMS Physicians Alliance staff member Rick Reas who serves as primary staff to the SMS Medical Liability Committee.

On the tax status question, Reas said the Internal Revenue Service maintains that WHCLIP's estimated $34 million reserve is surplus or "profit." (This figure does not include those monies set aside for payment of known or suspected claims.) "Potential tax liability is estimated by the IRS to be as much as $30 million."

To deal with the problem of MD refusal to serve on malpractice panels, a bill (AB 537) has been introduced in the state Legislature which would empower the panel director to refer physicians, who refuse to serve on a panel without good cause, to the Medical Examining Board. "Currently, there is no penalty for refusal to serve on a panel, even though the law requires MDs to serve," Reas said. "And that's one reason why so many physicians won't serve." The bill would also: (1) create more formal panels throughout the state to handle the caseload of about 250 claims per year, and (2) increase from $75 to $125 the compensation paid to panel members.

Finally, Reas noted that the State Medical Society has recently established a subcommittee of the Medical Liability Committee to study loss prevention activities. The subcommittee plans on taking its findings to the Board of Governors of WHCLIP.

William Treacy, MD, Milwaukee, elaborated on AB 537 pointing out that the bill establishes a "striking" system which allows parties in a panel action to request replacement of prospective panel members. He also discussed an arrangement made with the panel director which limits the involvement of physician panel members to a maximum of three cases which actually result in a hearing.

Walter Moritz, MD, Fort Atkinson, addressed the question of whether physicians should form their own malpractice insurance company. "If we do," he said, "we have to be prepared to deal with the physicians who aren't practicing 1981 medicine." Currently, WHCLIP accepts "all-comers" into the plan.

Doctor Moritz listed several factors which prompted SMS to undertake a study of alternatives to WHCLIP. Among them:

—The current New York State malpractice crisis where physicians are facing 70-150 percent premium increases.

—Frustration with the Board of Governors.

—The 1978 constitutional challenge to the panel system. What if this were overturned?

—The mood of the government. Both the Governor and the State Insurance Commissioner have taken the position that government should not be doing anything that private industry can do.

—Independent insurance agents are unhappy about SMS involvement with WHCLIP.

Referring to favorable WHCLIP rates, successful challenges to excessive increases in Fund fee assessments and the defeat of legislation which would have rendered the panels merely advisory, Doctor Moritz said, "If we have been successful in dealing with malpractice relative to the other 49 states, it's because we have been politically active." He urged physicians to continue their participation in WisPAC and legislative efforts.

As a final thought he warned physicians about getting involved in personal vendettas against other physicians. "Remember," he said, "doctors get doctors sued, patients don't get doctors sued."

V. David A. Kindig, MD

The new Vice Chancellor for Health Sciences at the University of Wisconsin outlined what he saw as priorities for health care in the next decade.

The number one priority, according to Doctor Kindig, will be health care costs. He said costs will continue to go up despite what actions are taken. He suggested that growth of health care expenses isn't necessarily bad. "It may be that individuals are willing to pay a high price for health care as they do in several European countries," he said.

"It is clear that government will get control of the 'uncontrollable' expenditures, that government regulation will fade, and that increased competition in health care will develop."

Doctor Kindig further proposed that the true costs of health care are not due to new technology and services, such as CT scans, but rather they have to do with individual professional decision-making. "As physicians, we must put more thought into our everyday decisions concerning health care delivery and utilization," he said.

He projected that provision of health care to the elderly will dominate public debate and overshadow general costs of hospital and medical care. "As the number of elderly on public assistance increases, we as professionals will have to deal with how to care for them," he said. "Social changes are needed to accomplish this and we will have to integrate health services into community service programs."

Doctor Kindig also forecasted high mortality and morbidity and social unrest in underserved areas in the next decade as assistance is cut to those areas.

"While maldistribution of physicians will largely be resolved in the next decade with the increased supply of physicians, nursing will continue to dominate the health manpower policy debate and nurses will push physicians to give them 'equal billing' on the health care team," he said.

Ethical, philosophical considerations in medicine and health care will continue to grow. "The rationing of health care—withholding of treatment—these are decisions that doctors are not taught in school, and they will take increasing amounts of our attention," he said.

In regard to the university and its relationship to the rest of the world, Doctor Kindig said that a university is often seen as an isolated community and that some of this is indeed necessary for it to carry out its work. His first priority as Vice Chancellor for Health Sciences will be to keep the university medical school viable to enable students to receive a quality education and become sound practitioners. "But an important second priority," he said, "will be to make the university more available to the public."

VI. The role of organized medicine in public and private proposals to change reimbursement of physicians

Albert J Motzel Jr, MD, Waukesha, President of the State Medical Society, led a lengthy and vigorous discussion of this subject. He urged physicians to read his series of articles on questions relating to reimbursement in the August through November issues of the *Wisconsin Medical Journal.* Each editorial deals with a separate phase of the complicated and controversial reimbursement problem.

Doctor Motzel urged that consideration be given to an indemnity fee approach to payment for physicians services. Pointing to what he believes is the ultimate inability of the "usual, customary, and reasonable" approach to perform acceptably, Doctor Motzel urged that some indemnity fee proposals should be tried on a limited representative scale. He had a four point suggestion:

1. Insurance carriers could delineate and categorize fees for all procedures for any given year. Each carrier could then determine what it considered the average, mean, or appropriate percentile of the usual charges and publish one of these measures of fees as their reimbursement methodology.
2. Unions and management could negotiate to purchase 100%, 110%, or lesser percentages of the average or mean fee published by a carrier. Patients (policyholders) would be fully informed of the amount of the fee being paid by the carrier.
3. Physicians could continue to charge whatever they wished.
4. The patient would pay the difference between the doctors charge and the fee reimbursement negotiated by the group. This

would assist economic competition, help the public to know what resources they would need in order to purchase a particular plan, and could if they wished shop around to their own advantage. The patient would be responsible to the physician, could evaluate the worth of services, would share in the responsibility for use and cost, and the effect would be to create a greater bond of understanding between doctor and patient.

Doctor Motzel suggested that inequities in fees under current reimbursement mechanisms were causing a considerable degree of difficulty. These are related to variations by training; variations by geography; initially high fees for experimental procedures which should in time go down but usually continue to rise; new practitioners receiving more than long term practitioners, especially from government programs; and inequity between specialties as to cognitive versus manipulative procedures. He urged that the Society attempt to find remedies for these issues which often create difficulties for physicians and certainly cause the public to be skeptical of the rationality and reasonableness of physicians charges.

Alwin Schultz, MD, Madison, President of the Dane County Medical Society, made the case for continuing reimbursement of physicians on the "usual, customary, and reasonable" basis.

He reported that the Dane County Medical Society, following extensive discussion, adopted a position in "opposition to implementation of a statewide uniform fee schedule and encouraging the retention of the usual, customary, and reasonable concept."

Support for the UCR approach was explained as follows:

1. A statewide uniform fee schedule fails to address the problem of physician specialists who have devoted many additional years of study to the development of their skills and expertise. In addition, it fails to take into account the higher liability insurance costs of specialists and particularly those specialties in which the cost of insurance may be 10 to 15 times higher than others.
2. Uniform fees do not consider differences in overhead between rural and urban areas. He gave as examples higher nurses salaries, office rents, hospital costs including such things as parking fees, and real estate taxes. He cited an example in which comparable homes in Thorp and Madison had differentials of $1,500/$4,000 for real estate taxes.
3. Medicaid pays from 45 to 65% of usual fees. Some areas of the state have a significantly higher percentage of indigent persons. Thus a larger financial burden is placed on the MDs practicing in those areas such as the inner cities or poorer counties. Uniform fees would place these physicians at a disadvantage.
4. There is fear that the uniform fee schedule would decrease the number of physicians who participate in the T-19 programs, thus possibly precipitating a crisis of access and service.
5. There is the prospect that if the state implements a uniform fee schedule for Medicaid, then insurance companies would follow suit in a short time.

In conclusion, Doctor Schultz suggested that the state give consideration to the purchase of HMP-type policies for T-19 patients and that MDs ought to agree to accept fees 50% less than their usual and customary for T-19 patients. This would reduce administrative costs for both physicians and the state in as much as the physicians would be dealing directly with an insurance company (thus reducing the paper work). In addition Doctor Schultz suggested that some arrangement be made to allow the physician who accepts a 50% cut for T-19 patients to consider some part or all of that 50% loss to be a charitable contribution and thus eligible for a certain type of deduction for income tax purposes. He urged that the State Medical Society explore these possibilities.

Vernon Griffin, MD, Mauston, made the case for development of a uniform fee schedule as the principal means of reimbursing physicians under T-19 in Wisconsin. He said, "We of the rural areas can understand usual and customary because we have been suffering and experiencing usual and customary to our detriment for all the years we have had Medicaid and Medicare."

"How can this be reasonable when we country folks are paying the same taxes to support Medicare and Medicaid as the taxes paid by our city friends, but we don't get back as much for equal work from these tax-supported programs as our city doctors."

Doctor Griffin declared that there "is little or no difference in the cost of medical practice and living in the rural and city areas, thus there should be no discrimination in fees. Actually rural doctors have to pay more real estate taxes, more for food, other necessities, utilities, and transportation costs and rural doctors do not have discount establishments, readily available supplies, and they need to travel a long way to get most of these things."

He said that "historically our own State Medical Society has gone on record more than once in favor of equal reimbursement for equal service regardless of the site of service in Wisconsin. We wish to take the geography out of reimbursement."

"The UCR profile as used in Medicaid is a deadly thing," Doctor Griffin said. "The new doctor who is not in the grip of the profile is paid more than the doctor of years in practice."

"I sent for my profile and it is 174 pages long, each about a foot high and if you stretch it out it would reach more than 170 feet. Each page has seven columns on it. Truly a monster. No wonder that the secretary of DHSS speaks of an extremely complex claims processing and pricing system for Medicaid which must recognize 2,500,000 separate prices for physicians' services."

"How do we accomplish a uniform fee schedule," he asked and then provided the following response:

"1. Let us do it carefully. Do not push the fee down to the lowest fee in Wisconsin. That would kill the Medicaid program by massive withdrawal. That has happened in other states. We should plan on having each fee at about the 70th to 75th percentile of current usual fees.

"2. Remove all geography so that the entire state of Wisconsin is on an equal basis of remuneration for the same service. Abolish the 13 geographic districts. This would reduce the number of different prices that would have to be paid under Medicaid to about 6,000 rather than 2,500,000.

"3. The important thing is for our State Medical Society to survive and for Medicaid to have physicians participating. Continuing financial discrimination against the rural physician in Medicaid reimbursement risks the massive withdrawal from both SMS and from MAP."

Charles Steidinger, MD, Platteville, President of the Wisconsin Academy of Family Physicians, proposed a tax credit concept as an alternate form of reimbursement to physicians of Wisconsin for services under Title 19. He suggests that none of the sincere and diligent efforts of physicians and DHSS to make the present system work are likely to succeed. Instead, he believes that an alternative system should be seriously studied which would utilize the concept of tax credits to establish a predictable budget for the state of Wisconsin, encourage physicians to carry out their moral obligation to provide health care to all citizens regardless of payment source, and assure all citizens on T-19 that they will be able to obtain necessary care.

Pointing to the fact that current reimbursement mechanisms provide a return of only 55 to 60% of billed fees by physicians, he suggests that some dramatic alternative is required. He feels that one "exciting" prospect is a tax concept which might work in principle as follows:

1. A budgeted total dollar figure for physician reimbursement for fees and services under Medicaid would be determined.
2. Distribution of this money would be to each participating physician on the basis of:
   (a) A fixed predetermined dollar amount per physician at *no* remuneration.
   (b) When the participating physician reached the total non-remunerated volume, he would be reimbursed for subsequent services at his usual and customary charges.
   (c) At the time the total dollar pool is expended, physicians would have to revert back to no remuneration for their services for the designated period of time.
   (d) The above concepts would be annualized but calculated on a monthly basis to prevent a cash flow hardship for physicians practicing in areas with a high percentage of medical assistance patients.
   (e) All fees for services to medical assistance patients would be billed to the Medical Assistance Program whether the physician had reached his maximum nonremunerative dollar amount or not.
3. Annually, at the end of each year, DHSS would provide participating physicians with certified forms that would indicate the charitable, nonremunerative volume of work done per physician for that year in addition to the total number of dollars received from the Medical Assistance Program for that year. The Internal Revenue Service and the Department of Taxation of the state of Wisconsin would then recognize the charitable, nonremunerative volume of work done by the physicians as charitable tax-deductible items.

Doctor Steidinger believes that the concept is worthy of consideration because it might demonstrate to the taxpayers, patients, and legislators that physicians are interested in caring for all patients regardless of their method of remuneration and that physicians are willing to lead the way in demonstrating a technique of fiscal responsibility.

The Wisconsin Academy of Family Physicians has requested assistance and analysis for this project. It is recognized the concept would require some time, effort and dollars to obtain state and federal approval, but he urged that the State Medical Society and other organizations actively involve themselves in determining the viability of such a proposal.

J D Kabler, MD, Madison, Chairman of the SMS Committee on Governmental Affairs, indicated that there are major political aspects of any fee reimbursement efforts. He said that the doctor's work week is declining, the number of patients being treated by each physician per week is declining and yet doctors' incomes continue to go higher. Thus, he said the public believes that doctors set their income goals and charge accordingly, and thus cost containment will never work.

Doctor Kabler suggested that some doctors are "professional buccaneers, charging what the traffic will bear, usually scandalously high fees, of which both the public and government are aware." He said, "reprisal is their response."

"No one can measure quality versus cost," according to Doctor Kabler. "This argument has lost its power to persuade."

The other end of the spectrum, according to Doctor Kabler, is the "medical mill" with those physicians who wish to operate a mill discarding "any sense of quality and relying entirely on large volume at low cost. Choice, not value, will be their determinant."

Russell F Lewis, MD, Marshfield, in audience participation, contended that SMS has not been able to attack the cost problem because while "the government charges physicians with inability to control fees, the government slaps us with a law suit if we try it." Other physicians questioned how doctors can do peer review of cost and quality without violating antitrust laws. H B Maroney, SMS Corporate Legal Counsel and Assistant Secretary, responded that "SMS can go after individual price pirates or quality pirates without violating any laws."

Doctor Lewis suggested that it would be much more satisfactory, if there is question about what medical societies can do to control costs, to "go directly to the state Legislature and ask for permission to discuss fee control and cost containment and to develop appropriate mechanisms to implement those goals."

Other physicians argued that "more training is not always more competence." It was reported that family practitioners "often have to assume the liability of specialists when specialists aren't available to provide certain services."

Still other physicians indicated that fees should be a reflection of "what's being done" rather than length of training. It was also suggested that productivity should be a major factor in income. One physician said, "We can't take as a given concept that five years of extra training should be authority for a physician to charge higher fees for the rest of his practice life. The public won't accept that."

Others countered that physicians in specialties tend to pay considerably more for liability insurance, thus need higher fees. Others argued that "if we do not allow a differential in fees, then a major competitive factor is removed."

Doctor Motzel pointed out that there is "substantial danger if there is too great a differential in fees and total income. This is diversive and convulsive among doctors especially when the difference in incomes is often six to ten times between doctors in different specialties."

The conclusion of this segment of the conference was to continue to explore all of the ideas that were presented, to negotiate with the Department of Health and Social Services as is currently being done through a special advisory committee to the Department (through the SMS Physicians Alliance Division), and to continue to inform physicians in depth at all levels of the organization on what the issues are and how they are being addressed.

VII. Political effectiveness—How can we keep it

"This is not the time for physician apathy in the world we currently find ourselves," SMS President-elect Gerald A Kempthorne, MD warned the physician leadership in attendance November 7. "Because of the current conservative image—we are being lulled into a sleep of a no crisis mentality with a 'no action' response," Doctor Kempthorne said.

He maintained that there is indeed a serious crisis facing medicine today when one considers the issues of uniform fees, the changing role of the Medical Examining Board, the Medicaid budget, the cost of medical care, and the changing role of the allied health professions.

"The political flavor of the moment is a delusion," Doctor Kempthorne warned. "With the costs of health care climbing astronomically, I believe the conservative security blanket we now are being warmed by will 'chill' into a crisis of change."

This new crisis will demand that the State Medical Society leadership set its priorities and concentrate on the issues affecting our profession and our patients, Doctor Kempthorne maintained. "We cannot be everything to everybody."

"If we place emphasis on the greater goals and missions of the Society, we will find ourselves spending less and less time on the minor

issues such as chiropractic, competition, free market, and the like," he said. "Certainly, we don't want to leave our benchmark in the eyes of the public simply on our victories over the chiropractors."

The question of whether there is a new role required for the Physicians Alliance was pursued by SMS Physicians Alliance Commission Chairman Kenneth M Viste Jr, MD. Doctor Viste said that since the Alliance was created in 1975, the State Medical Society has been very successful in its political action activities.

"At its base, the Physicians Alliance is a Madison lobbying effort," Doctor Viste said. "But equally important are the field or 'grassroots' activities which have helped to make physicians in their communities politically aware through monthly meetings between physicians and legislators at the local level."

While it is essential that we maintain this system for legislative contact and political action, Doctor Viste cited several elements which make up a "new role" for the Physicians Alliance.

"We must devote more attention to research analysis on issues such as HMOs and IPAs," he said. "Many physicians still don't understand the intracacies of this issue. We must therefore inform physicians so that they can make their own decisions when an HMO or IPA enters their community."

The Physicians Alliance Chairman also urged that more assistance be given to county medical societies on local political issues, greater use of media and public relations be made to inform the public of medicine's views, and increased aid be provided to medical staffs in their relationships with hospitals.

"Issue papers and tools such as the recent legislative issue guide prepared by the Alliance are very helpful to both physicians and other groups in letting them know where we stand on the issues," he said.

"Last but hardly least, the issue of costs must be dealt with by the Alliance," Doctor Viste said. "We must make a concerted effort to control costs in the near future."

These new tasks may require added staff expertise, more research, more education on the art of negotiations as well as more visibility for the Physicians Alliance as an integral part of the State Medical Society, according to Doctor Viste.

"More important, however, is that we work to procure adequate physician input. This means working to keep the good commission members and soliciting new advice and input from others."

VIII. Kenneth Rentmeester, Administrator, Division of Health

According to the new administrator of the State Division of Health, state government "can no longer afford to be on an adversarial track with physicians." Kenneth Rentmeester said that he viewed physicians as having "the most important role in health care."

"While physicians realize only 10 to 15 percent of the health care costs, they control 80 percent of what is being done in health care," Rentmeester maintained. "Because of this fact, physicians represent the 'key element' in controlling health care costs."

"The role of the government, too, must change," Rentmeester said, "from regulator to innovator and from controller to facilitator."

The Division of Health chief said that it was urgent that changes be made now in the Medical Assistance Program. "Since 1967 we have witnessed a 570 percent increase in Medicaid expenditures," he said. "If we don't stop this growth and make some changes now, Medical Assistance will devour our other health service programs and institutions relying on public support such as the university."

Rentmeester believes that the pragmatic alternative is to "redesign the system to provide both consumer and provider incentives to keep costs down."

He said, "consumers must be rewarded for appropriate, rather than maximum use of health services; nursing homes and hospitals need to be reimbursed according to efficiency, that is, on their cost per day and the type of service rendered to a given segment of the population, rather than being reimbursed for adding staff and services."

IX. Organizing for effective action

How well are we organized at the county medical society level? What could SMS be doing to better aid county societies? Do communications between SMS, the AMA, county societies, and specialty groups need strengthening?

In an effort to answer these and other questions, Board of Directors Vice Chairman Timothy T Flaherty, MD, Neenah, conducted a survey of Wisconsin's county medical society secretaries in October 1981. Of the 55 county societies, 30 responded.

"Most county medical societies meet regularly during the winter and seldom during the summer, although their executive committees tend to meet throughout the year," Doctor Flaherty said. Meetings are fairly evenly split between scientific (50%), socioeconomic and local business-procedural matters (33%), with social functions comprising 20% of the meetings.

"We must strive for uniformity of the county society election process," Doctor Flaherty said as the survey showed officers being elected at virtually all times of the year, but that officers usually took office at the first of the year.

"Nine of the 30 responding county societies said that they did not have an auxiliary and three of those nine said that they would not support the formation of one," he said.

Meeting attendance is a problem in some counties as 11 of 30 responding counties said they get 25% or less members attending regular county society meetings. Thirteen societies report 75% or more members attending meetings. One-half of the societies include meal costs in their dues.

"While most county societies have a president-elect," Doctor Flaherty said, "there continues to be reluctance among county medical societies to appointment of public relations chairpersons and program chairpersons. These positions are very important if a society is going to be an active force in the community."

New member contact is not actively done in many counties, as the vast majority of county societies said they wait until they receive applications from the new member. New members come in on invitation to CMS meetings by a CMS officer, referral from a CMS member, SMS field staff member, and hospital staff member in descending order of frequency.

"We must maintain liaison with the hospital medical staff in our local communities," he said. "The best way to achieve this is by appointing the hospital chief of staff to the county society executive committee." According to the survey, only four county societies have a hospital staff representative on the county medical society executive committee and only four have designated a county medical society representative to a hospital staff committee or executive committee.

"SMS publications such as *Medigram* and the *Wisconsin Medical Journal* continue to play the major role in informing county medical societies about SMS activities," he noted, "although county society presidents, SMS field staff, and SMS directors also help substantially in this regard." County medical society delegates to the SMS House of Delegates, as well as the lay press, could play a larger role in informing counties on SMS activities, according to the survey.

The survey asked county societies how the State Medical Society could better serve them. The most popular response was that SMS should provide "packaged" programming for county society meetings. "County societies want SMS speakers on SMS Services, Inc; on socioeconomic topics such as cost containment, health planning, professional liability and legislation; and on scientific topics such as impaired physicians and accredited CME," Doctor Flaherty pointed out.

Numbers two and three on the list were "more visibility of SMS field staff and SMS directors at county society meetings."

County medical societies are not interacting with many non-medical groups in their communities. "More than half the respondents said they have never scheduled meetings with business, labor, or civic leaders," Doctor Flaherty said.

What do county society secretaries feel are the most important issues facing medicine? The most critical issues were viewed as (1) the cost of medical care, (2) competition from non-MD providers, (3) surplus of MDs, and (4) Medicaid and Medicare. Least important to the secretaries were licensing requirements, CME changes, and limitation of charges of the "high rollers."

Conclusions and recommendations:

1. Stability and effectiveness of county societies depends on how they elect officers. Each society should have a president-elect to assure more experience in the top officer. Delegates to the House should serve on county society executive committees since they have experience and exposure. All societies should elect officers (and take office) in the same month.
2. Three committee persons are required (minimum): program chairman, Physicians Alliance chairman, and public relations chairman.

3. Videotapes should be updated; new ones offered.
4. SMS and counties should establish and publicize Speakers Bureau services for the public.
5. SMS should expand its service to provide scientific speakers for CMS meetings.
6. All county societies should increase liaison with hospital medical staff.
7. Use auxiliaries more—they are a great asset currently underutilized and underdeveloped.
8. Increase membership by 3% annually, and keep 99% of existing members.

X. SMS takes a look at itself

"Most of us are so busy doing the urgent things that we don't have time for the important things." This administrative principle can be applied to the State Medical Society of Wisconsin, according to the Chairman of its Board of Directors, Darold A Treffert, MD.

Doctor Treffert, in wrapping up the 1981 SMS Leadership Conference, asked the county, state, and specialty society leaders present to take the time to plan the priorities for organized medicine in the coming decade.

Doctor Treffert noted several problem areas that he would place on his priorities list.

"Complacency of members (not apathy) is one that plagues every organization and SMS is no exception," Doctor Treffert said. He saw this as the Society's biggest problem and one which he said we can't afford not to change. "We must be big enough and secure enough to seek out and to tolerate differences of opinion. Let's look at where people walk, then put the sidewalks where they ought to be."

More of the issues the county medical society used to deal with are not being dealt with at the State Society level, Doctor Treffert noted. "We must make every attempt at the state level to effectively communicate current developments to county medical societies." He proposed that this might be accomplished, in part, through expanded use of videotape and other "packaged" programs for CMS meetings.

Another concern of Doctor Treffert's is the "political preoccupation" of the State Medical Society. "Perhaps this is necessary," he said, "but we must not lose sight of other important endeavors such as public education and public health."

Once we have set our priorities, we must evaluate our effectiveness in a more systematic way," Doctor Treffert asserted. "To some degree, we have done this in the past by applying 'sunset' laws to Society commissions and committees."

Doctor Treffert further maintained that the Society's Board of Directors should "set the compass" for the organization and not, as he says, "become wrapped up in the managerial portion of it."

According to Doctor Treffert, the State Medical Society is, on the whole, spending its time and money on the right endeavors, and is organized adequately to serve physician interests.

In concluding his remarks Doctor Treffert asked the audience of 104 persons to participate in an informal opinion poll of their views on two questions:

1) What should be the top priorities for SMS in the five years ahead, and

2) What should SMS be doing differently.

The written responses were reviewed by Doctor Treffert following the meeting. The results are ranked by frequency of response as follows:

What are the top priorities for SMS in the five years ahead?

	Responses
1. Coping with the increasing intrusion of government into medicine by maintaining effective political action:	32
Preserving a pluralistic system of care.	
Preserve the professionalism of practice.	
Effectively dealing with governmental agencies and legislators, Governor, etc.	
Effectively dealing with health planners and third party pay organizations.	
2. Helping to solve the problem of rising health care costs:	17
Educating doctors about cost-containment.	
Interpreting health care costs and causes to the public.	
Educating consumers on cost-effective use of health care.	
Eliminating first dollar coverage.	
3. Maintenance of membership effort and membership communication:	13
Informing members more effectively.	
Increase and support auxiliary membership.	
Increased involvement of academia.	
Increased involvement, and voice, of younger members.	
Decreased distance between leadership and grass roots.	
Create in dues issue financial incentives to belong to SMS.	

What are the top priorities for SMS in the five years ahead?

	RESPONSES
4. Curtailing the intrusion into the practice of medicine by non-physicians and paraprofessionals.	7
5. Improving public relations/ public image: Establishing SMS as the voice of medicine statewide. Being pro-active rather than reactive. Presenting the physicians as patient-oriented rather than income-oriented. Talking about strengths rather than weaknesses.	6
6. Increasing emphasis on the Impaired Physician: More information about and access to impaired physician programs. Helping doctors and families deal with pressures of practice. Dealing swiftly and effectively with the "high rollers."	5
7. Improving Continuing Medical Education programming.	3
8. More attention to and direction in ethical issues.	2
9. More social concern.	1
10. An improved role and function of House of Delegates.	1
11. More leadership in health planning.	1
12. Inform members about HMO, IPA.	1
13. Inform members about role of computers in practice.	1
14. Constant surveillance of the malpractice situation.	1
15. Support the rural doctor and his small hospital.	1
16. More leadership in public health issues.	1
17. Provide position papers on key issues.	1
TOTAL	94

What should SMS be doing differently?

	RESPONSES
1. Reach more grass roots physicians to inform and listen; less isolation from the Board.	19
2. Present more positive, less self-serving image.	5
3. Be more aggressive in membership benefits such as SMS services and group purchasing, etc.	2
4. Be less adversarial with departments, bureaus, etc.	2
5. Be pro-active rather than reactive.	2
6. Not be so compromising with departments, bureaus, etc.	1
7. Have longer Board meetings (2-day).	1
8. Involve medical students more.	1
9. Provide HMO, IPA information.	1
10. Increased involvement of academia.	1
11. Educate members about burnout and coping.	1
12. Longer Annual Meeting forums.	1
13. More attention to World Health and public health problems.	1
14. Hold meetings such as this one geographically.	1
15. Set Work Week of Health date earlier.	1
TOTAL	40

■

—Report prepared by Diane Upton, Communications Coordinator

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Burn injuries in Wisconsin: epidemiology and prevention

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AN ESTIMATED two million people suffer burn injuries in the United States each year. Three hundred thousand of these seek medical attention and 130,000 require hospitalization, sometimes for as long as two years. The cost of burn injuries in terms of dollars spent and lives lost is great, indeed. An estimated $11.4 billion are spent each year as a direct result of burn injuries, and more than 10,000 burn-injured persons perish annually.[1,2] The cost in terms of human suffering, both physiological and psychological, is incalculable.

In Wisconsin burn injuries are no less a problem than in the rest of the country.[3] Although some of these injuries never come to the attention of a physician and others are treated in community hospitals, major burn injuries are usually referred to one of three regional burn centers. The burn center at St Mary's Hospital in Milwaukee receives most of the burn referrals from eastern Wisconsin. In northwest Wisconsin severely burned patients are treated at Ramsey County Hospital Burn Center in St Paul, Minnesota. From southwestern and central Wisconsin approximately 75 to 100 burn-injured persons are annually referred to the Burn Center at the University of Wisconsin Hospital in Madison. In addition to the roughly 300 burn patients admitted yearly to these three centers, a sizable number of burn-injured people die before they can be admitted to the hospital.

It is known from clinical experience and from the reports of others[2] that many burn injuries are preventable. To formulate a realistic and feasible burn prevention program for Wisconsin, the records of all cases seen at the University of Wisconsin Hospital Burn Center during a recent two-year period were reviewed. Based on these findings and the assumption that these are representative of burn injuries occurring throughout the state, recommendations for the prevention of such injuries have been prepared and are presented.

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Table 1—*Etiologies of burns*

ETIOLOGY	NO.	(%)
Flame	71	(50)
Scald (hot liquid)	48	(34)
Electrical	10	(8)
Chemical	3	(2)
Other	9	(6)
TOTAL	141	(100)

METHODS. All admissions to the University of Wisconsin Hospital Burn Center between January 1, 1978, and December 31, 1979, were reviewed. Age, sex, month in which burn occurred, type of burn (flame, scald, electric, chemical, or other), details of the burn scenario, relationship to work, and fatalities were evaluated. Each patient was counted on first admission only. Admissions for subsequent surgical or other treatment were not tabulated.

RESULTS. During the two-year study period, 141 patients were admitted to the University of Wisconsin Hospital Burn Center. Of these, 115 (82%) were male and 26 (18%) were female. The mean age was 28.6 years with a range from two weeks to 86 years. The median age was 25 years. Forty patients (28%) were 18 years of age or less. The age range with the highest frequency of burn injury was 21 to 30 years, which comprised 37 admissions or 26% of the total. Forty-nine admissions (35%) were for burns related to occupation, including homemaking.

Examination of the monthly distribution of burn injuries revealed that the majority of burns (67.4%) occurred during the warmer months, May through October.

Table 1 shows the frequency of burns by etiology. Gasoline fires were responsible for 28 (39%) of the flame burns. These frequently involved a motor vehicle or the use of gasoline to start a fire. Flammable gases were involved in 15 (21%) of the flame burns; half of these were during the lighting of a pilot light. House fires accounted for 15 (21%) of the flame burns.

Scalds from hot liquids comprised the next most frequent cause of burn injury. Hot water or steam was most commonly involved (50% of scalds), followed by hot oil and grease (27%) and hot beverages.

The majority of the electrical injuries resulted from contact with a high voltage wire. Chemical burns were caused by contact with cement, fertilizers, and ammonia. Other sources of burn injury were from a heating pad, hot wood stove, hot iron castings, space heater, exhaust pipe, a drive belt (friction burn), and smoke inhalation without burns.

Table 2 summarizes the etiology and epidemiology of the 18 fatal burns. Two-thirds of these burns were a result of flame burns: six from gasoline fires, four from explosions of flammable gases, and two from house fires. Scald burns accounted for four of the fatalities: three from hot tap water, all of which occurred in a bathtub, and one from hot oil spilled from a deep fryer. Two additional deaths occurred from electrical burns.

Children under the age of five were most commonly burned from hot liquids. Two of the four deaths in this age group occurred as a result of hot tap water scald burns in the bathtub. Another death resulted from contact with hot oil from a deep fryer. The fourth death resulted from a house fire. Children ages 5 through 15 years were frequently burned from contact with electricity or from playing with fire, especially matches and candles. Most of the burns in persons 15 to 30 years of age were a result of contact with flammable liquids such as gasoline involving a motor vehicle or starting a fire.

Table 2—*Burn fatalities*

Etiology	No. (%)	Age in years (sex)
Flame	12 (67)	
Gasoline	6	
Car/truck fire	3	18,20,35 (3 M)
Starting fire	1	86 (M)
Suicide	1	49 (M)
Tank	1	31 (M)
Gas	4	
Lighting pilot light	3	45-75 (2 M, 1 F)
Propane explosion	1	66 (M)
House fire	2	2, 35 (2 M)
Scald	4 (22)	
Bathtub	3	1½,2½,74 (1 M, 2 F)
Hot oil (deep frier)	1	1½ (M)
Electric	2 (11)	
Bare wire	1	83 (M)
Fuse box	1	28 (M)
Total Fatalities	18 (100)	(15 M, 3 F)

In adults over age 30, occupational (including farming and homemaking) and industrial burn injuries were among the most common. Small children and the elderly were most vulnerable to house fire injuries.

DISCUSSION. Our findings corroborated our clinical impression that most burn injuries are preventable. While poor judgment and negligence were ultimately responsible for most burn injuries, we could clearly discern epidemiological patterns of age, sex, season, place, and occupation among this group of burn patients.

Based on these statistics as well as on those gathered elsewhere,[2] a two-pronged burn prevention program consisting of legislative action and education was developed. In this paper we present the educational aspect of a program patterned after "Project Burn Prevention," from the Boston area, which was funded by the US Consumer Product Safety Commission. In Wisconsin, Project Burn Prevention of Wisconsin, Inc has been organized, and a pamphlet, "Protect Someone You Love,"[4] has been used to educate the public. Portions of the following information also are mentioned in that pamphlet.

Flame burns. Fires in houses and other buildings account for most burn fatalities. Many of these fires can be prevented by careful use of matches and cigarettes, appropriate storage of flammable materials, and careful use and maintenance of furnaces, wood stoves, ranges, space heaters, and electric wiring. Early detection of these fires, by use of smoke detectors, for example, is very important so that quick escape is possible. It is wise for the family to plan and rehearse evacuation routes and to have prepared escape ladders available for use, in the event of a fire.

Scalds. Scalds from hot tap water account for over 2600 emergency room visits in the United States each year. On the average these are more severe than other kinds of scald burns, with approximately 25% requiring hospital admission.[5] The crux of the problem is that water heaters have been preset by manufacturers at dangerously high temperatures and remain set at these temperatures even after installation in private homes. People who are exposed to these temperatures for even a brief time may suffer full-thickness burns which can result in permanent disfigurement and death. Those most frequently scalded are children, the elderly, and the handicapped who are physically incapable of removing themselves from scalding water in time to prevent a burn. In a review of tap water scalds from all hospitals in Dane County, Wisconsin, over a ten-year period, 33 such burns were found, including five fatalities.[6] Three of the five deaths occurred in children under the age of five years; the other two were in elderly patients (ages 74 and 84). All three toddlers had been left unattended by an adult, either

alone or with a slightly older sibling who was instrumental in the scalding.

The solution to this problem is to lower the maximum household water heater temperature to below 54.4C (130F), and preferably between 48.9 and 51.7C (120-125F). This can be stressed through a public education program which emphasizes energy conservation as well as safety. In addition, hot water heater manufacturers should be urged to lower factory preset temperatures. Until recently, electric water heaters were preset at the factory at 65.6C (150F) and gas water heaters were preset at 60C (140F). Investigators in Seattle tested hot water temperatures in bathtubs and found that the average hot water temperature was 61C (142F) and 80% were over 54.4C (130F).[7] At these temperatures occupants run the risk of full-thickness epidermal burns within two to six seconds.[8] Lowering the water temperature to 54.4C (130F) or below would allow most people enough time to remove themselves from the water before receiving full-thickness burns (Fig 1). A federal regulation has been adopted requiring all new water heaters to have attached labels warning of the danger of hot tap water. It is estimated that procedures such as these could reduce the number of tap water scalds by 75%.

In addition to hot tap water, scalds may be caused by other hot liquids, such as coffee, tea, or cooking oil. The victims of these scaldings are usually children under three years of age. Often these toddlers get burned as a result of pulling on a tablecloth, on a pot handle or cup, or on a dangling electrical cord from a cooking appliance, causing hot foods and liquids to fall on them. Especially in households with small children, pot handles should be turned toward the back of the stove, appliance cords should not be left to dangle from tables or countertops, and containers with hot liquids should not be set near table edges within reach of a toddler.

Scald burns are not restricted to young children, however. Eight males in our series, ages 16 to 47 years, were burned from the hot contents of a motor vehicle cooling system. This usually occurred when the cap was removed from an auto radiator while the engine was still hot. Allowing the engine to cool, prior to removing the radiator cap, is an obvious means of prevention.

Flammable liquids and gases. In the adolescent and young adult group, ages 15 to 30 years, the negligent or reckless use of gasoline is the single most frequently cited cause of burns. In many cases these burn patients are intoxicated at the time of their injury, and cigarettes are a common source of ignition. Burns related to recreation, such as those from campfires, lanterns, and camp stoves, are also common in this age group.

To help prevent these injuries, young people should be warned not to wear loose clothing while working around flames. Instead, they should be advised to wear short sleeves, to tuck in the loose ends of clothing, and to tie back loosely hanging hair. Many of the mod-acrylic fabrics are more flame-resistant than wool, nylon, or cotton.[4]

The most serious flame burns frequently involve an ignition source (a match or cigarette lighter) and a flammable liquid (invisible vapors). Vapor from such liquids may travel long distances along the ground in enclosed spaces; when the vapor reaches a flame, it can ignite explosively.

The public should be warned never to use a match to look for natural gas leaks or to relight pilot lights. The utility company should be called immediately to avoid an explosive ignition.

School safety and public education programs aimed at burn prevention should emphasize that if clothing catches fire, the person should drop to the ground and roll. Then burns should be cooled with cold water to reduce the depth of the burn as well as to alleviate pain.

SUMMARY. It is evident that burn injuries do not occur randomly.[9] Etiologic categories of burns are often specific for age, sex, season, and location. The definition of these factors will facilitate burn prevention programs that can be directed at those high-risk segments of the population for a given type of burn, thereby conserving funds and manpower without diminishing the effectiveness of the program.

Currently the Wisconsin Department of Agriculture, Trade, and Consumer Protection conducts a burn prevention education program throughout the state. People from the industrial community as

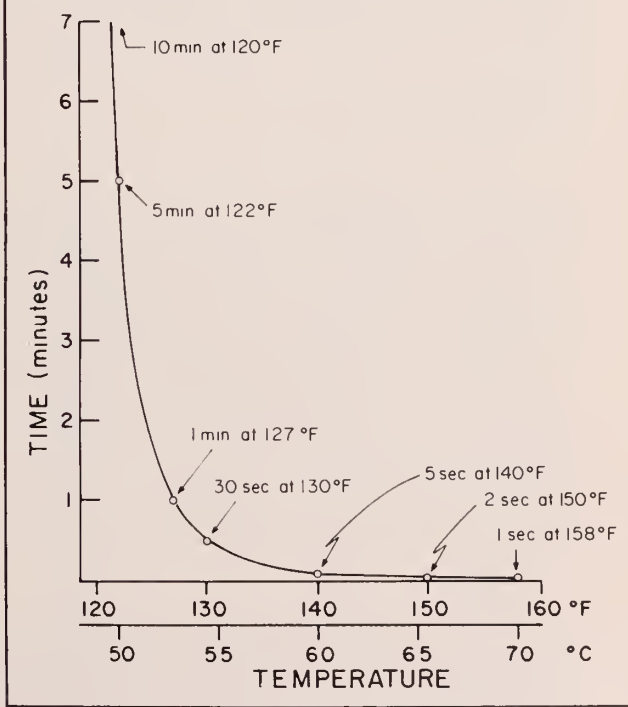

FIGURE 1—*Time/temperature relationship for full-thickness epidermal tap water scald burns* [Adapted by permission[6,8]].

well as educators, community leaders, and public service organizations have joined in this endeavor. Physicians can make an important contribution by instructing their patients, especially the elderly, the handicapped, and those with small children, about common burn prevention practices, as well as by participating in burn prevention education programs in the communities in which they live.

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Factor VIII usage in the Wisconsin Hemophilia Program; Factor VIII usage in hemophilia

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ABSTRACT. *The concept that early aggressive replacement therapy results in decreased morbidity and mortality has brought about the changing pattern of hemophilia care. This treatment program necessitates that large quantities of factor VIII therapeutic material be available. In an attempt to define the magnitude of the quantity needed, the present study of 51 hemophilia A patients involved in a comprehensive care program center describes the factor VIII usage per year per age group. The data can be used to inform suppliers and providers of hemophilia care with the amount of factor VIII units required per patient per year, thereby assuring adequate factor VIII replacement therapy.*

COMPREHENSIVE Hemophilia Diagnostic and Treatment Centers throughout the United States provide treatment plans for hemophilia patients of varying age groups.[1] Although total factor VIII usage per year is individually determined, it is highly variable depending on the severity of the disorder, body weight of the patient (dosage calculated per kilogram of body weight), type and site of hemorrhage (muscle, joint, intracranial), and the need for intermittent prophylaxis (physical therapy, surgical procedures, sports activities). As a result, hemophilia centers in conjunction with their factor VIII suppliers (blood banks, pharmacies), must be able to calculate the total factor VIII units per year required for treatment of their patient population in order to avoid shortages of factor VIII products.

Very few studies have taken into account the changing patterns of factor VIII replacement therapy referable to the increased number of surgical procedures, rehabilitative physical therapy programs, and the general encouragement of the hemophilia patient to treat suspected hemorrhagic episodes earlier and more aggressively. The present study analyzes 51 patients in an effort to describe the magnitude of the factor VIII consumption.

METHODS. The patient group consisted of 51 patients with severe classical hemophilia A (factor VIII procoagulant activity of <1 percent). None of the patients had inhibitors to factor VIII. Eight additional patients did not have data available for the year prior to entry but were included in the follow-up period. At the time of entry into the Hemophilia Comprehensive Care Center Program, patients were reoriented and reeducated in the philosophy of treatment; *ie,* early treatment at the onset of suspicion of an occurrence of hemorrhagic episode.[2,3] The follow-up period represents a time during which patient education emphasized early aggressive home infusion treatment as important for prevention of long-term disability.

Both cryoprecipitate and factor VIII commercial concentrates were used. Cryoprecipitate usage by bags was redefined as factor VIII units based on assays of cryoprecipitate ranging from 80-100 factor VIII units per bag. Prior to entry in the program, patients had utilized a dosage of factor VIII calculated to raise the circulating factor VIII level to 40%

At the time of this study Ms Lange was with the Great Lakes Hemophilia Foundation, Inc, 1701 West Wisconsin Ave, Milwaukee, Wis 53233; Doctor Lazerson was Associate Professor of Pediatrics, The Medical College of Wisconsin, and Medical Director of the Great Lakes Hemophilia Foundation, Inc. This study was supported in part by DHEW Grant No. MCB-55-001-03, the Faye McBeath Foundation Grant, and the Great Lakes Hemophilia Foundation. Publication support provided. Reprint requests to: Jack Lazerson, MD, Professor of Pediatrics and Pathology, University of California-Davis, Sacramento Medical Center, UCD Professional Bldg, 4301 X Street, Sacramento, CA 95817. Copyright 1982 by the State Medical Society of Wisconsin.

that of normal plasma (20 units of factor VIII administered per kilogram body weight). At the time of entry and during the follow-up period, patients were reeducated and instructed to utilize a lesser dose of 15 units per kg per infusion. *In vivo* factor VIII studies were performed periodically to monitor calculated values. Prophylactic use of factor VIII is defined as the infusion of 20 units per kilogram body weight given every other day. Mixed therapy is defined as the on-demand (prn) use of factor VIII to treat hemorrhagic episodes combined with intermittent interval use of prophylaxis. Surgical treatment regimens and postoperative rehabilitative periods are evaluated separately.

Usage of factor VIII in the year prior to entry into the program and in the follow-up period was obtained from monthly calendar reports and the patient's medical record.

RESULTS. Table 1 lists the age groups, number of patients, average weights, factor VIII units used per kilogram per year per patient population, and subgroups separated into the varied treatment regimens used; *ie,* demand, pure prophylaxis, mixed regimen of demand and prophylaxis, or surgical regimen. The average follow-up period for 59 patients was 20.5 months, with a range of 5-35 months. The average factor VIII usage for the total group increased from 49,712 units per patient to 101,588 units per patient and could be primarily accounted for by the prophylactic treatment regimens (surgical, mixed, and prophylaxis).

At the time of entry, 38 patients were on a demand regimen and 40 patients utilized this treatment modality during the follow-up period of 18.8 months (range 5-25 months). For those patients utilizing this treatment routine, in the less than six-year-old age group, the average follow-up period was 24.6 months, (range 12-35 months), with a 137% increase in factor VIII use. It should be noted that four of the nine patients in this age group had not used any factor VIII during the one year prior to entry. Exclusion of these four patients results in a change from 400 units/kg/year to 636 units/kg/year for five patients and a recalculation of percentage increase to 49% instead of 137%. The remainder of the demand treatment group revealed an increase in the amount of factor VIII used of 46-59%. The average units per kg of factor VIII used increased from 592 to 960, or a total of 26,700 units of factor VIII to 48,200 units.

Five patients utilized a prophylactic treatment regimen in the year prior to the date of entry into the program and four of these five patients were on this regimen during an average follow-up of 16.3 months, (range 5-25 months). It should be noted that the majority of patients using prophylactic therapy

Table 1—*Factor VIII usage*

Treatment Regimen	Age Range [years]	Prior To* Number Patients	Prior To* Average Weight [kg]	Prior To* Units Per KG Per Year	Follow-up Period† Number Patients	Follow-up Period† Average Weight [kg]	Follow-up Period† Units Per KG Per Year
	0-5	9	12.8	400	9	15.9	946
	6-10	5	25.7	557	5	32.2	824
	11-16	8	48.8	910	11	55.4	1444
	17-30	11	57.8	660	11	62.6	1014
	>31	5	80.7	391	4	84.8	571
		38	*45.2*	*592*	*40*	*50.2*	*960*
	0-5				1	23.9	3796
Prophylaxis	11-16	3	64.3	2456	3	52.8	2550
	17-30	2	61.7	2681	1	63.5	3043
		5	*63.0*	*2569*	*5*	*46.7*	*3130*
	0-5	1	19.5	3482	2	21.7	3171
	6-10	1	33.3	3934	2	29.9	708
Mixed	11-16	2	34.8	3934	6	62.3	2746
	17-30				3	67.8	1670
	>31				1	78.0	894
		4	*29.0*	*3783*	*14*	*51.9*	*1838*
	11-6	1	30.0	1605	1	57	8849
Surgical	17-30	2	76.6	2271	2	73.8	4744
	>31	1	75.5	994	1	68	403
		4	*60.7*	*1632*	*4*	*62.7*	*4599*
Totals or Averages		51	47.8	1040	59	53.1	1913

*12 month period.
†5-35 months.
Numbers in italics are totals or average figures.

were in the 11-to-30-year age group with no patients in the greater than 30-year age group.

Fourteen patients, an increase of ten patients, utilized a mixed therapy regimen during an average follow-up period of 11 months (range of 5-25 months) as a result of the recognition that an active physical therapy rehabilitative program requiring short-term intermittent prophylactic infusion would be beneficial. Despite this increase, no discernible patterns were noted in the amount of factor VIII used per kilogram per year per patient between the entry data and the follow-up data. The majority of patients, 9 of 14 (64%), using this approach to treatment were in the 11-to-30 year age group.

The results for patients utilizing surgical treatment regimens at entry and in the follow-up period did not reveal any consistent pattern in the use of factor VIII and was highly dependent on the nature of the surgical procedure and postoperative management. No surgical procedures were performed in patients less than ten years of age during the study period.

DISCUSSION. With the development of hemophilia comprehensive care programs, a reorientation and reeducation of patients with hemophilia is occurring. Patients are noting the advantages of early infusion treatment regimens, necessitating the availability of increased quantities of factor VIII.[4] The magnitude of this increase is variable; and if large enough, it may compromise factor VIII resources.[5] For this reason it is important to develop predictive indices based on factor VIII usage, utilizing number of variables. This will enable accurate projections of factor VIII usage to be provided to suppliers.

The data presented in this report, although representing a single treatment center's approach, reveal that there are two different patient populations. One, a younger patient group, is participating in a comprehensive care center continual education process approach to treatment from the time of initial diagnosis. These patients utilize therapeutic materials early and aggressively at the first suspicion of a hemorrhagic episode. The other group is an older, more static patient population saddled with chronic arthropathy and crippling deformities.[6] They have been reintroduced to the concept of effective therapy after having survived the ravages of this disorder without a philosophy of early treatment. The treatment of this latter group is often directed at rehabilitative measures, necessitating increased usage of factor VIII. This is demonstrated by the increased use of prophylactic infusions, mixed therapy, and surgical regimens necessary to rehabilitate the older population as compared to the relatively low use of these therapy regimens in the younger population. In fact, of the four patients less than 11 years of age using a mixed treatment program, one is a hyperkinetic syndrome child, who is periodically given prophylactic therapy to avoid intracranial hemorrhage due to his "head banging." Two other patients have significant arthropathy that requires intermittent prophylactic infusions which therefore accounts for the high factor VIII use in the group.

Exactly how much factor VIII will be required by any center will in part depend upon the number of patients in each of these groups, the type of therapy regimen these patients utilize, and the philosophy of the treaters. With the knowledge of such demographic data as age, weight, therapy regimen utilized, and number of severely affected individuals in their program, a center could easily calculate the number of units of factor VIII per kilogram per year per patient group necessary to effectively carry out treatment. Education designed to instill a philosophy of early treatment and home infusion has definitely increased the amount of factor VIII being utilized for patients less than ten years of age. Previous reports suggest that the use per year prior to and after home therapy programs for this age group is 11,100 and 17,800 units of factor VIII per patient respectively.[7] The present study reemphasizes the average increase of factor VIII from 8,000 units per patient per year to 21,200 units. A number of hemophilia programs, heavily weighted with patients older than 15 years of age, report that the average use of factor VIII per patient per year exclusive of surgery and prophylaxis, varies from 24,000 to 38,000 units.[8,9]

Our data indicate an even larger factor VIII unit usage per year despite a decreased unit per dosage per infusion recommendation; *ie,* 15 units per kg versus 20 units per kg. The unit usage per year is similar to the NHLBI's "Cooperative Study of Spontaneously Occurring Factor VIII Inhibitors in Patients with Hemophilia" study group[10] approaching 50,000 units per patient per year, for patients on an as-needed treatment schedule. The benefits of early treatment have been previously demonstrated including the fact that the amount of factor VIII per infusion can be decreased the earlier treatment occurs.[11] Of interest is the fact that the frequency of infusion appears to increase, averaging an infusion every eight days as the result of patients treating signs and symptoms that may or may not relate to an early hemorrhage episode.[12,13]

By 11 years of age through 30 years of age a percentage of patients had already encountered significant orthopedic problems. As a result, a number of these patients required prophylactic infusions and mixed regimens of factor VIII for rehabilitative procedures. Whether the children in the less-than-five-years-of-age and the six-to-ten-years-of-age groups will progress to similar problems remains to be assessed. Clearly, if this occurs, whether due to neglect or failure to avail themselves of aggressive treatment programs, the total factor VIII usage per patient per year may approach or exceed 100,000 units.

The relatively lower use of factor VIII in the older population, despite treatment regimen used, may represent a biologically preselected group; their counterparts who may have been high users of factor

VIII may have not survived. Evidence exists that severe hemophilia A is a heterogeneous disorder and therefore this present older subgroup may be a population not truly representative of the population that may now survive to adulthood.[14]

CONCLUSION. In maximizing hemophilia care through patient education and the development of home care infusion programs, an early aggressive treatment regimen is emphasized. To carry out this philosophy of treatment, adequate amounts of factor VIII products are required.

With the appropriate use of demographic data, a hemophilia center can calculate the approximate number of factor VIII units required and can therefore provide suppliers of factor VIII with appropriate information in order to avoid shortages of these materials.

ACKNOWLEDGMENT. The authors wish to thank Shelley Noble for technical assistance in the preparation of this paper.

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ABSTRACT

Safety of changing intravenous delivery systems at longer than 24-hour intervals

JEFFREY D BAND, MD and DENNIS G MAKI, MD (University of Wisconsin Hospital and Clinics, Center for Health Sciences, Madison, Wis) *Ann Intern Med* 91:173-178, 1979

Routinely changing the intravenous delivery system (fluid containers and administration set) every 24 hours is widely practiced in American hospitals to reduce the risk of septicemia caused by contaminated infusate. The authors did a prospective clinical study to ascertain whether changing at longer intervals could be justified. At the conclusion of infusion therapy through one system, both the cannula and an aliquot of remaining fluid were cultured quantitatively. Of 790 infusions, contaminated infusate was detected in one (0.39%) of 258 discontinued and sampled after 1 to 24 hours of continuous use, three (0.84%) of 359 after 25 to 48 hours, and one (0.58%) of 173 after 49 to 71 hours; none of these five contaminated systems produced septicemia. However, five cannula-related septicemias were identified during the study, none associated with concordant contamination of infusate. Routinely replacing the delivery system every 48 hours seems to be justified and could result in considerable savings to hospitals. Infection of the cannula wound and contamination of infusate seem to be unrelated. ■

An administrative medicine program for clinician-executives

DON E DETMER, MD and JAY NOREN, MD, University of Wisconsin Clinical Science Center, Madison, Wis: *J Med Educ* 56: 640-645 (Aug) 1981

An educational curriculum for clinician-executives has been developed at the University of Wisconsin-Madison. A comprehensive range of subjects is offered on flexible schedules, including weekends, to accommodate practicing health professionals. Courses may be taken for graduate credit leading to a master's degree in preventive medicine/administrative medicine or for continuing medical education credit. Course projects relate to problems or issues relevant to the student's work environment. The core curriculum includes: current health systems; healthcare management, planning, and evaluation; information sciences; values; and clinical preventive medicine. Degree requirements may be met in one full-time calendar year or over a several-year, part-time period. This curriculum has demonstrated the need for and value of programs directed toward strengthening the executive skills and roles of clinicians. ■

Bethanechol (Urecholin®) and bronchoconstriction

Sofjan Lamid, MD; Gerhard H Lohaus, MD; Usha Gokulananda, MD
Ahmed Z El Ghatit, MD; and **Omana George, MD,** Milwaukee, Wisconsin

BETHANECHOL (Urecholine®), a parasympathomimetic agent, has been used frequently in the management of patients with neurogenic bladder dysfunction.[1,2] Adverse reactions are uncommon; however, they include abdominal discomfort, excessive salivation, excessive sweating, exacerbation of asthma, and hypotension. Usage of the drug is contraindicated in those patients with hyperthyroidism, pregnancy, peptic ulcers, latent or active bronchial asthma, vasomotor instability, coronary artery disease, and Parkinsonism.[3] The purpose of this communication is to report an asthmatic attack that occurred in a patient who had no previous history of bronchial asthma and also was given bethanechol.

CASE REPORT. A 51-year-old white male was admitted for genitourinary evaluation. Since 1970 he had been a paraplegic with his level of injury at T6. Evaluation revealed persistently high residual urines in the range of 400 ml. The patient denied any history of asthma, peptic ulcer disease, thyroid disease, or drug allergy. The patient had never taken bethanechol before. A trial of bethanechol was initiated at 25 mg orally per dose. After the second dose the patient complained of increasing shortness of breath. Objective findings included tachypnea, prolonged expiratory phase of breathing, and wheezing over both lung fields. Atropine, 0.6 mg subcutaneously, and aminophylline, 200 mg orally, were administered without improvement. The patient was further treated with epinephrine, 0.3 mg subcutaneously, and subsequently terbutaline, 0.25 mg subcutaneously every six hours. In addition, aminophylline was given intravenously, with a loading dose of 6 mg/Kg followed with an infusion drip of 0.6 mg/Kg/hr.[4] Solu-medrol®, 100 mg intravenously every six hours, was also administered. The patient's wheezing and shortness of breath gradually resolved after three days of the above regimen.

This case illustrates that bronchoconstriction can develop with the use of bethanechol in a patient without a history of bronchial asthma. Within the past three years bethanechol has been used in our institution in 98 patients with spinal cord injuries resulting in detrusor muscle underactivity. Prior to this patient any adverse reactions encountered were minor.

Bronchospasm is a recognized reaction to bethanechol in patients with a history of asthma, but this is the first patient who had no previous history of asthma. Bethanechol is a choline ester and belongs to the same group of drugs as acetylcholine, carbochol, and methacholine. The smooth muscle of the bronchiole has both sympathetic and parasympathetic innervation. Stimulation of the parasympathetic innervation causes bronchoconstriction.[5] As is well known, in the transmission of a parasympathetic impulse, acetylcholine is liberated from the nerve endings, crosses to and stimulates the appropriate receptor, and then is quickly hydrolyzed by acetylcholine esterase. Bethanechol can stimulate these same cholinergic receptors. However, because it is resistant to hydrolization by acetylcholine esterase, its action is much more prolonged. Atropine can competitively block the effects of bethanechol; however, it should be given before the bronchoconstrictor effect fully develops. Once bronchoconstriction is present, treatment with sympathomimetic drugs is more effective in reversing the bronchoconstriction.

In conclusion, we would reemphasize that bethanechol (Urecholine®) can induce bronchoconstriction in persons without a prior history of asthma. If bronchoconstriction then develops, it is best treated with the use of sympathomimetic drugs, although atropine should also be given.

From Spinal Cord Injury Service (Doctors Lamid, Gokulananda, Ghatit, and George) and Pulmonary Disease Section (Doctor Lohaus), Veterans Administration Medical Center (Wood); and Departments of Physical Medicine and Rehabilitation and Internal Medicine, The Medical College of Wisconsin, Milwaukee, Wisconsin. Reprint requests to: Sofjan Lamid, MD, Spinal Cord Injury Service, VA Medical Center, 5000 West National Ave, Wood, Wis 53193 (ph 414/384-2000, ext 2875).
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ADVANCES IN EMERGENCY AND CARDIOVASCULAR CRITICAL CARE

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April 2, 3—symposium dates
April 1—ACLS Recertification Course
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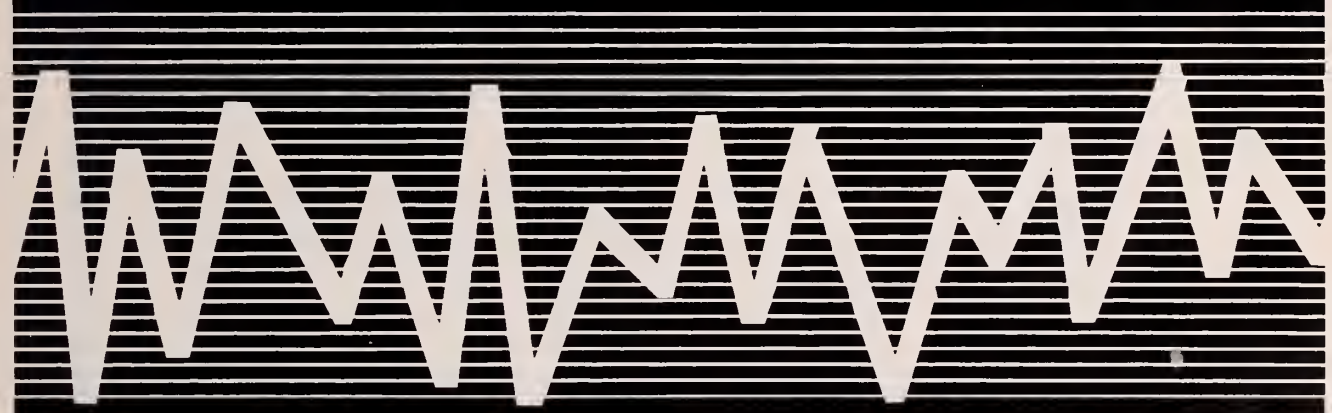

The conference will report on new treatment techniques and medications which have radically altered the management of the critically ill cardiovascular patient. Concurrent multi-level sessions are planned for physicians, nurses and paramedics. For information call or write: Mark Olsky, MD, Director, Emergency Services, Methodist Hospital, 309 West Washington Ave., Madison, WI 53703 (608) 251-2371.

THE STATE MEDICAL SOCIETY OF WISCONSIN

Created by the Territorial Legislature in 1841. . .representing over 5,000 member physicians in Wisconsin, comprising 55 county medical societies and 23 medical specialty sections. The purpose of the Society is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society include continuing medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, services for physicians, operation of a Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal.*

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Comedian Dan Ruskin set for Annual Meeting Dinner

Rapier wit. . .sometimes flip, sometimes literary, sometimes sassy, sometimes off-beat, and always humorous. THE WASHINGTON STAR

That's just what one entertainment critic had to say about Dan Ruskin who will provide the entertainment at the Presidents' Dinner Thursday, May 13, during the 1982 SMS Annual Meeting.

A talented pianist, a versatile actor, a prolific and creative songwriter, and an astute satirist, Dan Ruskin puts on a performance that is sure to delight SMS physicians and their spouses.

Dan Ruskin

Ruskin, who has written for Mark Russell, has also appeared in movies such as *Annie Hall* and *The President's Analyst*. On television you might remember him from appearances on *The Electric Company, Feeling Good, Get Smart*, or more likely as the actor in Gillette's Dry Look or Ultrabrite Toothpaste commercials.

Physicians won't want to miss what promises to be a most enjoyable and entertaining evening with Dan Ruskin. Further information about tickets for this program will be contained in the Annual Meeting Brochure coming in physicians' mail soon. ■

Annual Meeting schedule

Thursday, May 13: County, district, specialty caucuses—7 - 9 AM, MECCA. First Session, House of Delegates—9 - 12 N, MECCA. Reference committees—1 - 4 PM, Hyatt. HMO-IPA Seminar—3 - 5:30 PM, Hyatt. Presidents' Reception and Dinner (50-Year-Club Dinner)—7 PM, Hyatt.

Friday, May 14: Medicine and Religion Breakfast—7 AM, Hyatt. Scientific Sessions—8:30 - 11:45 AM, MECCA. Socio-economic/WISPAC Luncheon—11:45 AM - 1:30 PM, Hyatt. Scientific Sessions—1:30 - 5 PM, MECCA. Second and Third Sessions, House of Delegates—1:45 - 5 PM, MECCA. Past Presidents' Dinner—6 PM, Hyatt. Specialty Society Dinners—6 PM, various places.

Saturday, May 15: Scientific and Socio-economic Sessions—8:30 AM - 4:30 PM, MECCA. Specialty Society Dinners—6 PM, various places. ■

CES FOUNDATION

CONTRIBUTIONS—NOVEMBER 1981

The Charitable, Educational and Scientific Foundation of the State Medical Society is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for November 1981.

Unrestricted

CA Olson, MD; Ferdinand O Grassl, MD; HJ Kief, MD; Jacob M Fine, MD; AA Holbrook, MD; Margaret C Winston, MD; SMS Members—*Voluntary Contributions*

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SMS House of Delegates 1982 resolution deadline reminder. County medical societies, specialty sections, and SMS members who wish to submit a resolution to the 1982 SMS House of Delegates Annual Meeting May 13-14 must send their resolutions in proper form to the Secretary's office at SMS no later than March 13, 1982.

Early submission of resolutions is encouraged in order to facilitate early distribution of materials and allow all delegates to adequately represent their county medical society or specialty section.

A "fiscal note" must accompany any resolution involving expenditures. ■

Milwaukee Medicine Honors its Own

Glenn H Franke, MD* was installed as president of the Medical Society of Milwaukee County (MSMC) January 14 at the 135th Annual Meeting of the group in Milwaukee. Doctor Franke succeeds Charles W Landis, MD* who will continue to serve on the Society's Board of Directors.

Other physicians who assumed elective offices for 1982 at that meeting are: Richard D Fritz, MD*—president-elect; Robert J Flemma, MD*—secretary-treasurer; Robert F Madden, MD* and Charles L Junkerman, MD*—directors-at-large.

Derward Lepley Jr, MD* received the MSMC Distinguished Service Award and retiring board members Marvin Glicklich, MD,* John P Mullooly, MD,* Shimpei Sakaguchi, MD,* and Henry M Waldren Jr, MD* were honored for their years of service to the Society's Board of Directors.

Paul G LaBissoniere, MD,* received a certificate of appreciation for his work as an SMS District 1 Director (formerly Councilor).

MSMC life memberships were awarded to the following physicians who have each served the profession for fifty years: David J Ansfield, MD;* Boris I Bender, MD;* Hubert J Farrell, MD;* James J King, MD;* Lois H Kretchmar, MD;* Michael J Kuhn Sr, MD;* Anthony S Kult, MD;* Isadore B Reifenrath, MD;* and Charles S Stern, MD.*

Life memberships in the State Medical Society were awarded to the following past presidents of SMS from Milwaukee: Robert E Callan, MD;* Robert F Purtell Sr, MD,* and Jules D Levin, MD.*

Work goes on to contain medical costs in Brown County

Brown County Medical Society physicians and members of local industry and business have been engaged in talks in the last several months to slow the growth of industrial medical costs for workers.

This liaison with business and industry on the cost issue grew out of an SMS House of Delegates resolution introduced by the Medical Society last year which pointed out 29 measures doctors could take to help control medical care costs.

According to Stephen Hathaway, MD, Green Bay, chairman of the liaison committee, the Medical Society realized that a need existed for improved communication between medicine and business.

"Concern over the cost and delivery of medical care is a valid one," Doctor Hathaway says. "Our efforts are directed towards developing a program of cost-effective, high-quality healthcare services for business and industry personnel in Brown County."

Since it has begun meeting, the committee has developed two tools for local physicians: a "return to work" form to inform personnel departments about the status of injured and sick workers, and a booklet telling them who to contact to learn about an employee's job description before deciding when s/he can go back to work.

For industry, a booklet listing available physicians and their specialties is being prepared.

Doctor Hathaway further stresses the need for patient education about the cost of medical care.

"We have to get across the idea that there is no free lunch," he says. "People have to recognize that it is coming from someplace. It is going to cost them other benefits or something else."

KENOSHA: Kenosha County Medical Society members have elected the following new officers for 1982: president-elect—Harold A Bjork, MD,* Kenosha; delegate—Douglas G Devan, MD,* Kenosha; alternate delegates—William J Jeranek, MD* and Mariano F deGuzman, MD,* both of Kenosha. The following physicians continue in office: president—Lee H Huberty, MD,* Kenosha; past president—A James Bennett, MD,* Kenosha; secretary—Anoo P Patel, MD,* Kenosha; delegates—Clifton E Peterson, MD,* Kenosha, and Joyce E Yerex, MD,* Racine; and alternate delegate—Meredith C Clubb, MD,* Kenosha.

WAUKESHA: A life membership in the State Medical Society was awarded to Albert J Motzel Jr, MD,* Waukesha, who will become a past president when his term as president ends in May. The Waukesha Society also granted exemption from future county medical society dues for Doctor Motzel as a token of the appreciation of the membership for the valuable service he has performed. Future meetings: March 3 at Lohmann's Steak House in Menomonee Falls, with discussion of a proposal for a free clinic in Waukesha. April 7 at one of the country clubs—Merrill Hills, Chenequa or North Hills—or the Steeple Chase Inn. May 5 at the Western Racquet Club, with discussion of resolutions to be acted upon at the State Medical Society House of Delegates Annual Meeting, May 13-15, in Milwaukee. June 2 at the Golden Mast, with election of new officers. The Auxiliary also will hold its annual auction at this time. ■

WHETHER TO INCORPORATE

COUNTY AND SPECIALTY societies who have questions regarding incorporation, in what category they should seek tax exemption, and the mechanics of doing either or both of these are encouraged to consult H B Maroney, State Medical Society assistant secretary and corporate legal counsel, at SMS headquarters in Madison.

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FORM APPROVED OMB NO. 0938-0008

PATIENT & INSURED (SUBSCRIBER) INFORMATION

1 PATIENT S NAME *(First name, middle initial, last name)*	2 PATIENT S DATE OF BIRTH	3 INSURED S NAME *(First name, middle initial, last name)*
4 PATIENT S ADDRESS *(Street, city state, ZIP code)*	5 PATIENT S SEX MALE ☐ ☐ FEMALE	6 PATIENT S I D NO AND/OR MEDICARE NO *(include any letters or code)*
	7 PATIENT S RELATIONSHIP TO INSURED SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐	8 INSURED S GROUP NO /MEDICAID NO *(include any letters or code)*
9 OTHER HEALTH INSURANCE COVERAGE Enter Name of Policyholder Plan Name Group No or other	10 WAS CONDITION RELATED TO A. PATIENT S EMPLOYMENT YES ☐ ☐ NO B. AN AUTO ACCIDENT YES ☐ ☐ NO	11 INSURED S ADDRESS *(Street, city, state, ZIP code)*
12 PATIENT S OR AUTHORIZED PERSON S SIGNATURE *(Read back before signing)* *I Authorize the Release of any Medical Information Necessary to Process this Claim or Related Claims* *I Request Payment of MEDICARE Benefits Either to Myself or to the Party Who Accepts Assignment Below* SIGNED DATE		13 *I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICES DESCRIBED BELOW* SIGNED *(Insured or Authorized Person)*

PHYSICIAN OR SUPPLIER INFORMATION

14 DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)		15 DATE FIRST CONSULTED YOU FOR THIS CONDITION	16 HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS YES ☐ ☐ NO	16a IF AN EMERGENCY CHECK HERE ☐
17 DATE PATIENT ABLE TO RETURN TO WORK	18 DATES OF TOTAL DISABILITY FROM	THROUGH	DATES OF PARTIAL DISABILITY FROM	THROUGH
19 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE *(e g , public health agency)*			20 [illegible] O HOSPITALIZATION DATES	DISCHARGED
21 NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED *(If other than home or office)*			?FORMED OUTSIDE YOUR OFFICE?	CHARGES
23 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY RELATE DIAGNOSIS TO PROCEDURE IN CO A 1 2 3 4			NO ☐ NO ☐	

24 A DATE OF SERVICE	B PLA OF SERVI										LEAVE BLANK

25 SIGNATURE OF PHYSICIAN OR SUPPLIER *(Note Provider or supplier signing this claim acknowledges and certifies to the statements appearing on the reverse side of this form)* SIGNED DATE	26 ACCEPT ASSIGNMENT SEE BACK YES ☐ ☐ NO	27 TOTAL CHARGE	28 AMOUNT PAID	29 BALANCE DUE
	30 YOUR SOCIAL SECURITY NO	31 PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE AND TELEPHONE NO		
32 YOUR PATIENT S ACCOUNT NO	33 YOUR EMPLOYER I R S NO			

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3 — INPATIENT HOSPITAL	6 — INDEPENDENT LAB	9 — NOT USED

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Chiro insurance bill defeated for third session in a row

The Wisconsin State Senate January 28 handed the Wisconsin Chiropractic Association its third straight defeat in as many sessions as it voted 23-10 to defeat Senate Bill 603. The bill proposed that all health insurance policies sold in Wisconsin be required to include chiropractic services whether the potential insured desired the coverage.

Voting without a word of debate, the original motion for passage was defeated when three senators—Scott McCallum of Fond du Lac, Gary George of Milwaukee, and Gerald Kleczka of Milwaukee—quickly changed their votes to support SMS. Senator Kleczka's switch was expected in order to permit a vote for reconsideration.

Optometry insurance bill advances. In another vote taken January 28, the State Senate passed Senate Bill 316 on a 27-6 vote.

SB 316 requires coverage of optometrists for health insurance plans or contracts extending coverage for vision care services.

Unlike SB 603 which mandated chiropractic care in insurance policies, SB 316 does not mandate vision care which will continue to be an optional item. However, if there is coverage for vision care services or procedures, those policies will no longer be able to limit the coverage to physicians only.

The bill prohibits insurers from refusing to provide coverage for vision care services or procedures provided by an optometrist, within the scope of optometric practice, if the contract or plan includes coverage for the same services when provided by a physician.

Senate Bill 316 is request legislation by the Wisconsin Optometric Association. The State Medical Society opposes the bill because it restricts the insurance-buying public's freedom to choose only the coverages they desire. Senators voting against the bill were Donald Hanaway, Rod Johnston, Barbara Lorman, Paul Offner, Fred Risser, and Jerome Van Sistine.

The bill is now pending in the State Assembly.

Determination of death bill wins Assembly appeal. The State Assembly passed Senate Bill 327 in late January relating to the determination of death, on a vote of 91-3.

In each session since 1977 the State Medical Society has supported a statutory recognition of brain death which paralleled accepted medical standards for the determination of death.

SB 327 incorporates the model language developed by the AMA and American Bar Association into statutory law.

The bill sets forth two criteria for determining death—one based on irreversible cessation of circulatory and respiratory functions, and the other based on irreversible cessation of all functions of the entire brain, including the brain stem. Both determinations of death must be made in accordance with accepted medical standards.

Earlier in the session the Senate passed SB 327 on a 27-6 vote. The bill now awaits the Governor's signature. Once law, Wisconsin will join some 28 other states with similar statutes. ■

State claims $2.8 million savings in second opinion program

The Second Surgical Opinion Program (SSOP) has netted nearly $2.8 million in total savings since it began in February 1981, the State Dept of Health and Social Services (DHSS) has claimed in a report on the program it gave to the Legislature January 1.

Furthermore, DHSS cites a drop in surgery rates for SSOP procedures between 29% and 54% depending on the procedure. The Department attributes 90% of this decrease to the "sentinel effect"—the phenomenon whereby the existence of the second opinion program indirectly affects physician behavior when they know their recommendations for surgery will be reviewed.

Under the Second Surgical Opinion Program, Medicaid patients are required to obtain a second opinion on ten surgical procedures as a condition for payment under the T-19 program.

The State Medical Society, in written comments sent to the Department, charged that the savings claim was a "gross overestimate" and was unjustified by the research methodology and length of time the SSOP has been in operation.

SMS said independent reports from hospitals on the number of actual surgeries being performed on T-19 patients show a much higher incidence of surgery than reported by EDS Federal Insurance as paid claims—data used by the Department in its report.

The Society also objected to the use of estimates of physician, hospital, and other costs rather than the actual charges paid by T-19 when the latter are available.

Despite these perceived shortcomings, the Society urged continuation of the program to allow evaluation for at least two years from the time surgery was first proposed for SSOP procedures.

The Legislature, in enacting the Second Surgical Opinion Law, mandated that DHSS make its first report on the effectiveness of the program to the Legislature by January 1, 1982.

The Second Surgical Opinion Program will terminate on June 30, 1982 unless the Legislature authorizes its continuation. (Also see related editorial in this issue.) ■

Governmental Affairs reviews new legislation

The SMS Commission on Governmental Affairs reviewed a legislative proposal January 13 which would require physicians to inform their patients about the availability of all alternate and viable modes of treatment and about the risks and benefits of these treatments.

While the Commission formally took no position on the bill (AB 941), it felt that the legislation was unnecessary because the issue is already case law which was reaffirmed in 1975 by the Wisconsin Supreme Court.

Rep Betty Jo Nelson (R-Shorewood) says she introduced the bill in order to call attention to the need for physicians to discuss alternative treatments for breast cancer with women who need their help.

In other action the Commission:

- **Supported AB 920** which revises the law providing for conversion or continuation options for persons who terminate coverage under a group health insurance program.
- **Supported AB 930** which would give the Controlled Substances Board *statutory* authority to monitor the illegal diversion of Schedules II, III, IV, and V controlled substances.
- **Supported AB 246** which established a system in the Dept of Health and Social Services for disclosure of information on an adopted child's birth parents and to conduct searches for birth parents at the child's request. The bill specifically outlines medical record information the birth parents are required to file with the court at the termination of parental rights. No information may be revealed until the child reaches age 21, and the birth parent(s) also agrees to be identified. ■

Psychotherapy services under T-19 subject of SMS survey

All Wisconsin psychiatrists are encouraged to respond to a survey mailed to them in late January by the SMS Committee on Mental Health regarding their participation in the Wisconsin Medical Assistance Program.

The Society is attempting to compile reliable, statewide data on past, current, and future Medical Assistance billing practices to share with a committee being assembled by State Rep Dismas Becker to examine possible alternative reimbursement plans for mental health services.

The State Legislature recently announced several changes concerning reimbursement for delivery of mental health services under the Medicaid Program. One of the major changes would require psychiatrists to contract with the 51.42 Community Mental Health Board for the county in which a patient resides in order to be reimbursed for psychiatric evaluations, psychotherapy, and alcohol and other drug abuse treatment under Medicaid.

Reimbursement of care for Medicaid recipients ages 22-65 will require the authorization of the 51.42 Board for both hospitalization and the delivery of mental health services.

The Society has submitted the names of SMS Mental Health Committee Chairman Pauline M Jackson, MD, LaCrosse and Committee member Charles W Landis, MD, Milwaukee, to Representative Becker to serve as SMS representatives on his committee. ■

Society urges passage of smoking regulation bill

At another public hearing in January the State Medical Society supported passage of Senate Bill 80 which would prohibit smoking in certain public facilities and would require others to post smoking and no smoking signs.

Citing the experience of a member of his own family, SMS Secretary Earl R Thayer told members of the Assembly State Affairs Committee January 19 that secondhand smoke in a restaurant recently caused his grandson to have a severe asthma attack and be rushed to the hospital emergency room.

"When someone you love risks death when exposed to smoke, you become convinced a sign is a small price to pay for protection," Thayer said.

The SMS Secretary said the bill would help get the message across to the public that smoking is not only an unhealthful and costly practice but also that it is not a socially-accepted practice in all public settings.

The passage of SB 80 would serve to make smokers themselves more aware of the consequences of their habit while at the same time protecting the health and personal rights of nonsmokers.

Senate Bill 80, which has already passed the Senate, is now pending in the Assembly State Affairs Committee. ■

1982 SMS Annual Meeting: May 13-15
Milwaukee—MECCA and Hyatt Regency

'GUIDELINES FOR DETERMINATION OF DEATH' PUBLISHED. "Guidelines for the Determination of Death," part of a report from the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, has been published in the *Journal of the American Medical Association* (Nov. 13, 1981). The document is a summary of currently accepted medical practices for the determination of death, both cardiorespiratory and neurological (brain death). The criteria take into consideration new technologies in the laboratory confirmation of the diagnosis of death, and are the first update of standards for brain death since 1968. ■

Panel revision bill goes to public hearing

Passage of a bill making a number of revisions in the Patients Compensation Panels system will result in a "more efficient and effective resolution of medical liability disputes," William L Treacy, MD, Milwaukee, told members of the Senate Judiciary Consumer Affairs Committee January 21. Doctor Treacy, a member of the SMS Medical Liability Committee and Board of Directors, testified on behalf of SMS at a public hearing on AB 537.

Developed by an Ad Hoc Committee on Patients Compensation Panels consisting of representatives from the Medical Society, hospital association, and legal profession, the bill will empower the panel director to refer to the Medical Examining Board physicians who refuse to serve on a panel without good cause.

Other provisions of the measure include: creating more formal panels throughout the State to reduce the backlog of cases and allow for timely resolution of disputes; promoting greater use of the informal panels by raising the dollar threshold for informal panels from $10,000 to $25,000; establishing a "striking" system which allows parties in a panel action to request replacement of prospective panel members, and increasing the compensation paid to panel members from $75 to $125. ■

Pharmacy Board backs off from MD dispensing proposal

The Pharmacy Examining Board has decided to drop its plans to license and otherwise regulate dispensing physicians. In late January the Board agreed to support a substitute amendment to Senate Bill 437 drafted by State Senator Gary Goyke (D-Oshkosh) which deletes several provisions that were opposed by the State Medical Society.

The substitute amendment deletes a provision allowing physicians to only *dispense* medications, not prepare and compound as they currently are allowed to do by law. The new proposal will also attempt to equalize fines for pharmacists and physicians who violate labeling and recordkeeping laws.

The original bill would have required physicians to maintain a medication profile record system for each patient. The SMS Governmental Affairs Commission had maintained that the patient's medical record would serve this purpose in lieu of a profile system. Senator Goyke has incorporated this recommendation in his substitute amendment.

It is expected that SB 437 will be reported out of the Senate Human Services Committee within the next few weeks. ■

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Advisory commitee for post-moratorium plan in place

A 15-member "blue ribbon" committee to advise the Legislature in developing a plan for post-moratorium regulation of hospital and nursing home construction was announced January 28 by the Department of Health and Social Services Secretary Donald Percy.

Members appointed to the committee are: Earl R Thayer, SMS Secretary; Sen Paul Offner (D-LaCrosse); Rep John Robinson (D-Wausau); Warren von Ehren, Wisconsin Hospital Association; Roger Baird, State Health Policy Council; Sheldon Goldberg, Wisconsin Association of Homes for the Aging; Gordon Gronert, State Dept of Administration; I A Zyduck, Wisconsin Physicians Service; James Bouman, Consumers United; Thomas G Dehn, MD, Foundation for Medical Care Evaluation of Southeastern Wisconsin; Paul Fleer, Health Planning Council, Inc; Thomas G Girard, Blue Cross and Blue Shield United of Wisconsin; Gordon J Decker, Allis Chalmers; John W Schmitt, AFL-CIO; Louise G Trubek, Center for Public Representation.

In 1981 the Legislature imposed a moratorium on major hospital and nursing home construction which will end in mid-1983. DHSS is required to present its post-moratorium planning system to the Legislature by February 1983. ■

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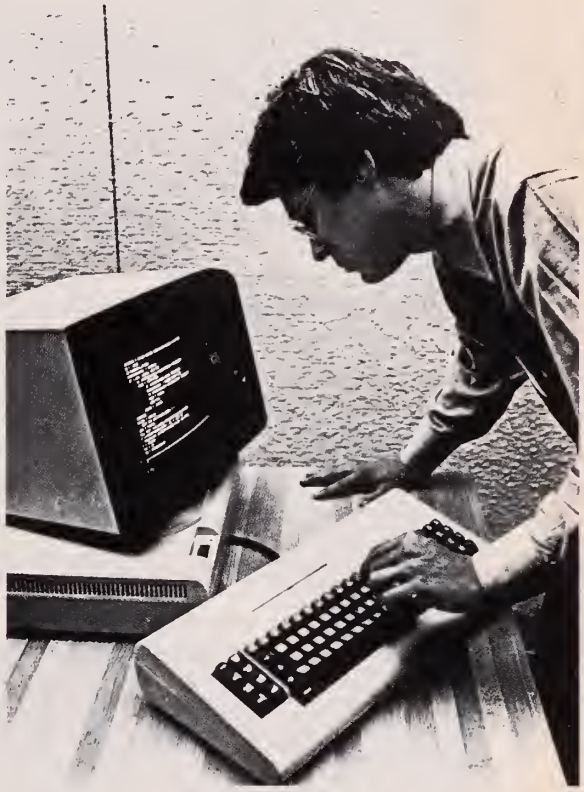

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Physician Briefs

*Physician members of State Medical Society of Wisconsin

George L Lucas, MD,* Madison, recently took office as president of the American Association for Hand Surgery. His term expires in October 1982. George J Korkos, MD,* Milwaukee, is a member of the Board of Directors and his term expires in 1983. The Twelfth Annual Meeting of the Association will be held October 7-10, 1982 at the Hyatt Regency Hotel on Kaanapali Beach, Maui, Hawaiian Islands.

Paul H Steingraeber, MD,* LaCrosse, recently was certified by the American Board of Obstetrics and Gynecology. Doctor Steingraeber is a member of the Department of Obstetrics and Gynecology of the Skemp-Grandview-LaCrosse Clinic.

Kok-Peng Yu, MD,* Madison, recently joined the Department of Pediatrics of the Jackson Clinic, Madison. Doctor Yu graduated from the State University of New York Medical Center, Syracuse, and completed his internship and residency at the University of Wisconsin in Madison.

Rudolph C Hecht, MD,* Madison, associate professor of Family Medicine at the University of Wisconsin, recently was a visiting professor at the two medical schools in Cordoba, Argentina. While there he also served as consultant to a number of provincial teaching hospitals, specialty societies, councils, colleges, and federations who are interested in establishing training and recognition of family practice as a specialty.

Jacqueline J Wertsch, MD,* Wauwatosa, recently was appointed as an assistant professor of physical medicine and rehabilitation at the Medical College of Wisconsin, Milwaukee. Doctor Wertsch graduated from the Medical College of Pennsylvania and completed a fellowship in physical medicine and rehabilitation at MCW affiliated hospitals. She also served a residency at Northwestern University Medical Center.

Alan A Wartenberg, MD,* Milwaukee, recently was appointed as an assistant professor of medicine at the Medical College of Wisconsin, Milwaukee. Doctor Wartenberg graduated from the Medical College of Wisconsin, Milwaukee, and completed his residency at MCW affiliated hospitals. He was assistant medical director at DePaul Rehabilitation Hospital and has done research on alcoholism and drug abuse.

Andrew J Taylor, MD, Wauwatosa, recently was appointed as assistant professor of radiology at the Medical College of Wisconsin, Milwaukee. Doctor Taylor graduated from Northwestern University Medical School and served his residency training at MCW affiliated hospitals. He is based at the Milwaukee County Medical Complex.

Paul M Grossberg, MD, Madison, has joined the medical staff at the DeForest Medical Clinic in the Department of Pediatrics. Doctor Grossberg graduated from the State University of New York Medical School and completed his residency at the University of Wisconsin, Madison. Prior to joining the Clinic, Doctor Grossberg was the medical director at the Student Health Center at the University of Wisconsin, Platteville. He also maintains a faculty position as an assistant professor of pediatrics at the University of Wisconsin Hospital & Clinics, Madison.

James Logan, MD, Mauston, recently joined the medical staff of Mile Bluff Medical Center. Doctor Logan graduated from Southwestern Medical School, Dallas, Tex, and served a residency in pediatrics at Norton Children's Hospital in Louisville, Ky. He also spent two years in family practice residency at the Regional Medical Center in Madisonville, Ky.

Thomas L Zurbriggen, MD, LaCrosse, has joined the medical staff of the Gundersen Clinic in LaCrosse. Doctor Zurbriggen graduated from the University of Iowa School of Medicine and completed his internship and residency in internal medicine at the Clinic.

Walter R Schwartz, MD,* Wauwatosa, has been elected vice chairman of the Wisconsin section of the American College of Obstetricians and Gynecologists. He will serve for three years. Doctor Schwartz is a graduate of the University of Wisconsin Medical School, Madison, and served his residency at the Milwaukee County Medical Complex. He is associate clinical professor in the department of gynecology and obstetrics at the Medical College of Wisconsin, Milwaukee.

Jerome S Mayersak, MD,* Merrill, recently was inducted as a fellow of the International College of Surgeons. Doctor Mayersak is the consulting urologist at several hospitals in northern Wisconsin, including the Flambeau Medical Center, Park Falls; Sacred Heart, Tomahawk; Taylor County Memorial Hospital, Medford; and the Langlade County Memorial Hospital in Antigo. He also is a member of the medical staff of the Holy Cross Hospital in Merrill. Doctor Mayersak is a graduate of the George Washington University School of Medicine in Washington, DC.

Dennis G Greer, MD,* Wautoma, recently became associated with the medical staff of the Marshfield Clinic and its Wautoma Center facility. Doctor Greer graduated from the University of Missouri Medical School, Kansas City, and completed his family practice residency at the Oklahoma University Health Sciences Center, Oklahoma City, and at Tulsa Medical College.

Frank Gutmann, MD, River Hills, recently received a 1981 Outstanding Physician Award at the Heart Association of Wisconsin's annual meeting. Doctor Gutmann earned the award for his contributions to the cause of the Health Association through medical practice and public education.

William J Carlson, MD, Appleton, is the new family practitioner at the Medical Arts Clinic in Brillion. Doctor Carlson graduated from the University of Wisconsin Medical School, Madison, and completed his family practice residency at the University of Minnesota in St Paul. Prior to moving to Appleton, Doctor Carlson had lived in Shawano where he was the emergency room physician.

J Garry Sack, MD,* Wausau, recently was named a fellow in the International College of Surgeons. He is a graduate of the University of Missouri-Columbia Medical School, and served his internship and residency at the University of Wisconsin Hospital & Clinics in Madison.

Ben R Lawton, MD,* Marshfield, recently was named to the Governing Council of the Institute of Medicine. Doctor Lawton has been a member of the Institute since 1977 and his three-year term began in January. He had served as president of the Marshfield Clinic for eight years; is a member of the Clinic's Executive Committee of the Board of Directors; and is vice president of the University of Wisconsin Board of Regents.

Charles Thurston, MD, Iola, recently opened his medical practice in Iola. He graduated from the Medical College of Ohio, Toledo, and served his residency at Riverside Hospital in Toledo. Doctor Thurston was in clinical practice in Marfa, Tex, and also served in emergency rooms in rural southwestern Texas.

Lee R Feierabend, MD, Marshfield, has joined the medical staff of the Marshfield Clinic in the Department of Surgery, Section of Plastic Surgery. Doctor Feierabend graduated from the Baylor College of Medicine, Houston, Tex, and completed his residency at the Baylor Affiliated Hospitals in Houston. Prior to locating in Marshfield, Doctor Feierabend was engaged in private practice with the MacGregor Clinic in Houston.

Dennis G Greer, MD, Wautoma, recently joined the medical staff of the Marshfield Clinic and its Wautoma Center facility. Doctor Greer graduated from the University of Missouri Medical School, Kansas City, and completed his residency in family practice at the Oklahoma University Health Science Campus, Oklahoma City, and at Tulsa Medical College. Prior to moving to Wautoma, he was in private and emergency room medical practices in Broken Arrow and Collinsville, Okla.

Carol Pierce, MD and **John F Myers, MD,** recently became associated with the Antigo Medical Center. Doctor Pierce graduated from Southwestern Medical School, Dallas, and served an internship at University of Vermont College of Medicine and Medical Center Hospital. For the past three years Doctor Pierce has been at the Louisiana State University Medical Center, Shreveport, La. Doctor Myers graduated from the Medical College of Wisconsin, Milwaukee. His residency in internal medicine was completed at the University of Missouri in Columbia. ■

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AMA Physician's Recognition Award Recipients

LISTED BELOW are those physicians in Wisconsin who have earned the AMA Physician's Recognition Award in recent months. The award was established in 1969 "to recognize, encourage and support physicians who participate regularly in continuing medical education and to emphasize the importance of developing more meaningful continuing medical education opportunities for physicians." A minimum of 150 credit hours of CME must be earned over a three-year period to qualify for the award. The hours may include such activities as conferences, residencies, teaching, writing, private reading, listening to cassettes, home study courses, consultation, and peer review; at least 60 of the hours, however, must be from formal CME programs sponsored or cosponsored by organizations accredited for these activities. The State Medical Society of Wisconsin congratulates the following physicians who have distinguished themselves and their profession by their commitment to continuing education:

NOVEMBER 1981

*Abdallah, Wadie A, Cudahy
*Arvold, David S, Shawano
*Bachhuber, Gregory J, Wausau
*Baier, Armin R, Wauwatosa
*Bartl, George R, Waukesha
*Bernas, Alex, Milwaukee
*Blank, Roy C, Manitowoc
*Bliwas, Crain H, Milwaukee
Bowers, Timothy L, Oshkosh
*Brister, G H, Wausau
*Buck, Charles E, Green Bay
*Caffrey, James P, Green Bay
*Campbell, Craig W, Columbus
*Caskey, Harry S, Clintonville
*Chessin, Henry, Appleton
*Clasen, Richard W, Wisconsin Rapids
*Cook, Steven, Chippewa Falls
*Criswell, David K, Beloit
Damos, James R, Reedsburg
*Dernbach, William K, Wausau
*Derus, Gerald J, Madison
Edwalds, Robert M, LaCrosse
*Evans, Michael R, River Falls
Fisher, Robert L, LaCrosse
*Fogleman, James D, Waukesha
*Frazin, Lawrence J, Milwaukee
*Fulks, Michael W, Eau Claire
*Garland, Thomas P, Milwaukee
*Gerndt, Harold L, Manitowoc
Gleysteen, John J, Milwaukee
*Goldstein, Paul H, Milwaukee
*Goswitz, John T, Manitowoc
Graziano, Franklin M, Madison
*Hardie, Gordon H, Neenah
*Hathway, Stephen D, Green Bay
*Haug, Stephen L, LaCrosse
*Hillan, Donald D, Waukesha
*Hofmeister, Frederick J, Milwaukee
*Jacobs, Paul A, Milwaukee
*Jacobson, Lewis L, Eagle River
*Janssen, Martin L, Friendship
*Jeffrey, James S, Kaukauna
*Johnson, Paul S, Racine
*Johnson, Samuel B, Green Bay
*Junkerman, Charles L, Milwaukee
*Kalush, Samuel L, Milwaukee
*Kanemoto, Henry H, Wausau
*Kanin, Harry J, Milwaukee
*Katzoff, Michael N, Milwaukee
Kaufman, Stuart D, Eau Claire
*Kjentvet, Roger A, Wild Rose
*Kuglitsch, John F, Fond du Lac
*Laserna, Ramon V, Montello
*Malloy, Thomas G, Milwaukee
*March, Jack F, Algoma
*Marksan, Leonard S, Milwaukee
*Martinez, Francisco J, Hales Corners
*Mc Avoy, Paul B, Neenah
*Mendeloff, Gale L, Milwaukee
*Nellen, James R, Greendale
*Nelson, Leo K, St Croix Falls
Nevels, Zebedee J, Milwaukee
*Peters, Earl, De Pere
*Peterson, Stanley E, Stoughton
*Pinegar, Kenneth G, Marinette
*Pomainville, Leland O,
Wisconsin Rapids
*Price, Daniel J, Milwaukee
*Qureshi, Mehboob M, Monroe
*Raettig, James A, Monroe
*Ravelo, Henry V, Milwaukee
*Rosenbrook, Gordon H, Bloomer
*Ruggaber, Garren C, Brookfield
*Sager, Mark A, Manitowoc
*Sarnecki, J C, Neenah
*Shealy, C Norman, LaCrosse
*Siegel, Morris, Kenosha
*Skupniewicz, Raymond E, Racine
*Smith, Franklin A, Appleton
*Steiner, John H, Waupaca
Stenburg, Walter P, Milwaukee
*Stevens, Michael L, Marshfield
*Strimling, Arnold M, Franksville
*Taber, Alan, Berlin
*Tauke, Ralph E, Tigerton
*Teplin, Ervin, Milwaukee
*Trepanier, Gay D, Fond du Lac
*Vande Loo, Francis B, De Pere
*Viernes, Patricio, Wauwatosa
*Weissler, Joseph B, Appleton
*Wilson, Louis J, Eau Claire
*Witteman, George J, Wausau
Zundag, T D, Eau Claire

DECEMBER 1981

*Ansaldo, Oscar P, King
*Barrette, Antoine, Peshtigo
Basich, John E, Hales Corners
Brinton, Gregory S, Milwaukee
*Brooks, Jerome C, Racine
*Brown, Jack D, Sparta
*Calado, Brigido C, Watertown
*Chamoy, Lewis, Milwaukee
*Cline, Ross L, Monroe
*Cronin, Robert P, Milwaukee
Davenport, Gordon, Madison
*Dedmon, Robert E, Neenah
*Elias, Sharon L, Milwaukee
*End, Jack A, Milwaukee
*Fenlon, Charles E, Appleton
*Flannery, John V, Wausau
*Forkner, William R, Kohler
*Han, Paul Z, Wausau
*Harvey, Richard F, Madison
*Hoehne, Kurt A, Oshkosh
*Hogan, John P, Milwaukee
*Ives, Donald G, Milwaukee
*Jachowicz, Robert B, Hales Corners
*Kempton, Leo V, La Crosse
*Khanna, Trilok S, Janesville
*Kirchner, John P, Marshfield
*Klein, Ronald, Madison
*Kochar, Mahendra S, Wood
Kolesari, Gary L, New Berlin
*Langheim, Werner, Madison
*Lehman, Roger H, Wood
*Lipoff, Jay I, Milwaukee
*Lorenz, Albert A, Eau Claire
Mauthe, Howard, Fond du Lac
*Mayhew, Duane G, Milwaukee
*Mc Beath, Andrew A, Madison
*Morgan, Claud E, Nashotah
*Nelson, Eugene J, Sun Prairie
*Patel, Malti M, Waukesha
*Peterson, Douglas B, Marshfield
*Pinkus, Walter H, Racine
*Polacek,, Michael A, Milwaukee
*Price, David L, Appleton
*Raduege, William E, Woodruff
*Rawlins, Steven J, Beaver Dam
*Resan, Thomas K, Woodruff
*Roberts, Cameron F, La Crosse
*Samadani, Ayaz M, Beaver Dam
*Schleper, Albin J, Racine
*Schmidt, Lou R, Sparta
*Schmitz, Robert C, Madison
*Schwarz, Robert L, Menomonee Falls
*Scudamore, Harold H, Monroe
*Shah, Asghar A, Sheboygan
Shetty, K Rajmohan, Wood
*Siegel, Lawrence K, Waukesha
*Spear, Jack, Richland Center
*Steingraeber, Paul H, La Crosse
Stengel, Bruce F, Wood
*Stram, Thomas W, Marshfield
*Swanson, John D, Neenah
*Taylor, Neal, La Crosse
Tempelis, Laurence D, Wauwatosa
*Treffert, Darold A, Fond du Lac
*Utrie, John W, Green Bay
*Wartenberg, Alan A, Wauwatosa
*Whaley, Ralph C, Barron
*Wynn, Sidney K, Milwaukee
*Young, William W, St Croix Falls
*Zarwell, David H, Milwaukee■

*Members of the State Medical Society of Wisconsin

Kenosha Memorial Hospital medical staff has elected Stanley S Rosen, MD* as its new president. Doctor Rosen succeeds Winston I Corzine, MD. Other officers elected were MDs Roger T Pecanowski,* vice-president and Suresh R Naik,* secretary. Named as at-large members of the staff executive committee were MDs Louis Olsman,* Nesim Halfon,* and Walid Burhani.* Chairman of the Department of Surgery is Meredith C Clubb, MD* and Ernesto E Buencamino, MD* is chairman of the Department of Medicine. David W Davis, MD* was reelected chairman of the Department of Pediatrics.

Community Memorial Hospital, Menomonee Falls, recently announced that Douglas O Clark, MD,* Brookfield, has taken office as president of the medical staff. Doctor Clark has served on the medical staff since 1971. He is an assistant clinical professor in the Department of Obstetrics and Gynecology at the Medical College of Wisconsin, Milwaukee, and a lecturer for the Nurse Practitioner Program of Planned Parenthood of Wisconsin.

Wausau Medical Center, at its annual meeting, elected William K Dernbach, MD,* as its new president. Doctor Dernbach succeeds David K Aughenbaugh, MD.* A member of the Department of Internal Medicine since 1976, Doctor Dernbach has served as vice-president of the Center and has been a member of the center's executive committee. Other officers elected were MDs Edgar B Koschmann,* vice-president, and Richard C O'Connor, MD,* secretary-treasurer.

St Nichols Hospital, Sheboygan, has announced its new president of the medical staff. Otto K Stewart, MD,* Sheboygan, succeeds Burnell F Eckardt, MD,* for the year 1981-82. Other officers elected were Paul M Fleming, MD,* vice-president, and James B Kuplic, MD,* secretary-treasurer. Doctor Stewart graduated from Georgetown University School of Medicine, Washington, DC, and completed his residency at Duke University in Durham, NC. He completed a tour of duty in the United States Army and has practiced medicine in Sheboygan for the past 20 years. He served as president of the Piedmont Orthopedic Society in 1981.

American College of Physicians, Philadelphia, has announced the election of two new Fellows from Wisconsin. The Physicians will be formally inducted at the College's Annual Session in Philadelphia, April 19-22, 1982. They are Steven R Gambert, MD,* Bayside, and Patrick T Regan, MD* from Milwaukee.

American Academy of Dermatology recently awarded Howard M Temin, PhD, Madison, the 1981 Lila Gruber Memorial Cancer Research Award. Doctor Temin, professor of oncology at the University of Wisconsin Medical School's McArdle Laboratory for Cancer Research in Madison, was the sole recipient of this year's award; in the past, it has usually been shared by two scientists. He accepted the award at the annual conference of the Academy in San Francisco where he presented a lecture on "RNA Tumor Viruses as Natural Genetic Engineers." Doctor Temin was a co-winner of the Nobel Prize for Medicine in 1975. ■

Medical Assistants

FEBRUARY 1982

PROFESSIONAL DEVELOPMENT AND ADVANCEMENT SEMINAR

Sheraton Inn, Madison Saturday, March 13, 1982

The American Association of Medical Assistants, Inc, Wisconsin Society, will sponsor a Professional Development and Advancement Seminar at the Sheraton Inn, Madison, on Saturday, March 13, 1982.

The morning session will be held from 8:30 am until 12 noon, and the instructor will be W Pharis Horton, Attorney. His subject will be "Law and the Medical Assistant." Attorney Horton is a graduate of Dartmouth College and Georgetown University Law Center. He has practiced law in Madison since 1963. The afternoon session will be held from 1:00 pm until 3:00 pm and the speaker will be Dolores Niles. Her subject is entitled "Women's Rights as Patients and Employees." Ms Niles has received her BS and MS in Social Work from the University of Wisconsin, Madison, and has done graduate field work at the Mendota State Hospital and the Wisconsin School for Girls, and Rutgers Summer School of Alcohol Studies in New Brunswick, New Jersey.

For further information on the March Seminar, please contact Carol Prahl, 1019 W Roberts Ave, Appleton, Wis 54911.

Isabelle W Comande
Public Relations Chairman
AAMAI, Wisconsin Society
815 Kingston Ave
Racine Wis 53402 ■

Obituaries

Alfred J Klein, MD, 70, Eau Claire, died Jan 19, 1981 in Eau Claire. Born Oct 2, 1910 in Chicago, Ill, Doctor Klein graduated from the University of Illinois Medical School and served his internship and residency at St Luke's Hospital in Chicago. He was appointed assistant professor at the University of Chicago Department of Medicine in 1939, served as a lieutenant colonel in the United States Medical Corps during World War II, and served on the medical staff of Luther and Sacred Heart hospitals in Eau Claire. He was a member of the Eau Claire-Dunn-Pepin County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association. Surviving are his widow, Geraldine; two daughters, Susan Ackley, Minneapolis, Minn, and Mary Klein, Washington, DC.

Martha Rosin, MD, 77, Sturgeon Bay, died Aug 24, 1981 in Sturgeon Bay. Born Dec 30, 1903 in Northeim, Germany, Doctor Rosin graduated from Albert Ludwig University in 1930, and served her residency in Hamburg, Germany. Doctor Rosin practiced medicine in the Chicago area for 30 years before moving to Sturgeon Bay in 1972. She was a member of the "50 Year Club" of the State Medical Society of Wisconsin. She also was a member of Door-Kewaunee Medical Society and the American Medical Association. Surviving is one sister, Frieda Rosin of Sturgeon Bay.

Albert T Hume, MD, 76, Temple, Tex, died Oct 25, 1981 in Temple. Born Nov 30, 1904 in Urbana, Ill, Doctor Hume graduated from Washington University School of Medicine. Doctor Hume practiced medicine in the Chetek area during the late 1930s. Surviving is his widow, Theo Welch Hume of Temple, Tex.

Arthur E McMahon, MD, 86, former Menomonie resident, died Oct 25, 1981 in Mason City, Iowa. Born June 5, 1895 in Green Bay, Doctor McMahon graduated from the University of Iowa College of Medicine in 1924 and served his internship at Denver General Hospital, Denver, Colo. Doctor McMahon was a member of the Menomonie Clinic until his retirement in 1977. He was a member of the "50 Year Club" of the State Medical Society of Wisconsin, a member of the Pierce-St Croix County Medical Society, and the American Medical Association. Surviving are one son, Dr Arthur McMahon, Mason City, Iowa; and two daughters, Helen Teeple, Guthrie Center, Iowa, and Martha Butler, Minneapolis, Minn.

James R Fant, MD, 65, Whitefish Bay, died Nov 11, 1981 in Whitefish Bay. Born June 24, 1916 in Indianapolis, Ind, Doctor Fant graduated from Indiana University School of Medicine in 1940. His internship was served at Indiana University Hospitals, and his residency was completed at Cook County Hospital, Chicago, Ill. Doctor Fant served in the United States Army Medical Corps from 1943-1946. Surviving are his widow, Dorothy; one son, James, and three daughters, Sally, Peggy, and Sheree.

Kenneth P Schroeder, MD, 49, Oconomowoc, died Nov 13, 1981 in Oconomowoc. Born Jan 12, 1932 in Milwaukee, Doctor Schroeder graduated from Marquette University School of Medicine in 1961 and served his internship at Milwaukee County Hospital and University Hospital, Madison. Surviving are his widow, Beverly; and children, Kenneth, John, Julie Schroeder; Leslie Tanin, Jim, Jerry, and JoAnne Metzger.

Hazel P Lescher, MD, 54, Brookfield, died Nov 15, 1981 in Brookfield. Born February 12, 1927 in Sydney, Australia, Doctor Lescher graduated from Sydney University Medical School in 1951, and her internship was served at Orange Base Hospital in Australia. Her residency was completed at Washington DC General Hospital. She was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and the American Medical Association. Surviving are three children.

James W Sargent, MD, 63, Fox Point, died Nov 17, 1981 in Fox Point. Born Apr 4, 1918 in Milwaukee, Doctor Sargent graduated from the University of Michigan School of Medicine in 1943 and served his internship at the United States Naval Hospital, Bethesda, Md. His residency was completed at the Mayo Clinic, Rochester, Minn. He served in the United States Navy from 1943-1946. Doctor Sargent served as president of the Wisconsin Urological Society in 1961. Surviving are his widow, Ruth; one son, James C, Fox Point; and two daughters, Virginia Soch, Baltimore, Md and Marjorie Sargent, San Rafael, Calif.

James R Regan, MD, 77, Wauwatosa, died Nov 20, 1981 in Milwaukee. Born September 29, 1904 in Milwaukee, Doctor Regan graduated from Marquette University School of Medicine and completed his internship at Milwaukee County Hospital. His residency was served at Wood Veterans Administration Hospital. Doctor Regan also completed a fellowship at New York Post Graduate Hospital. He was a member of the Milwaukee Orthopedic Society, American College of Surgeons, The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and the American Medical Association. Surviving are his widow, Vi; and two sons, Dr Michael of Medford, Oregon and James P of Los Angeles, Calif.

Frederick G Joachim, MD, 72, Hilton Head, SC, died Nov 23, 1981 in Hilton Head. Born July 2, 1909 in Chicago, Ill, Doctor Joachim graduated from the University of Wisconsin Medical School, Madison, in 1933 and served his internship at Lutheran Hospital, LaCrosse, Wis. His residency was completed at the University of Wisconsin General Hospital in Madison. Doctor Joachim had practiced medicine in Madison from 1935 until his retirement in 1978. He had served in the United States Army Medical Corps from 1941-1946 during World War II. He was a member of the Wisconsin Surgical Society,

Fellow of American College of Surgeons, and Diplomate of the American Board of Surgery. He was a member of Dane County Medical Society, State Medical Society of Wisconsin, and American Medical Association. Surviving are his widow, Kathleen; and four children, Frederick G, Dr Richard J, Dr Catharine L, William K, and one grandchild.

Sydney C Jackson, MD, 93, Madison, died Nov 28, 1981 in Madison. Born Aug 12, 1888 in Madison, Doctor Jackson was the son of pioneer surgeon Dr James A Jackson. He was a veteran of World War I. Doctor Jackson was the last surviving member of the founders of the Jackson Clinic in Madison. He retired from medical practice while in his late 70s. While in his 60s he recorded many six-mile swims in Lake Mendota and swam into the month of November. Doctor Jackson also went whitewater canoeing on the Wisconsin River at the age of 90. He graduated from the University of Colorado School of Medicine in 1923 and practiced medicine for a short time in California.

Wilson S Phillips, MD, 68, Sarasota, Fla, died Nov 28, 1981 in Milwaukee. Born Mar 4, 1913 in Milwaukee, Doctor Phillips graduated from the University of Wisconsin Medical School, Madison, in 1936 and served his internship at Mount Sinai Hospital in Milwaukee. His residency was completed at Stanford University Hospital in San Francisco, Calif. Doctor Phillips was director of the anesthesiology department at Mount Sinai Hospital, Milwaukee, from 1945 until 1970; a senior consultant in anesthesiology at the Veterans Administration Hospital, Wood; and a clinical professor of anesthesiology at the Medical College of Wisconsin. He was a former president of the Wisconsin Society of Anesthesiologists, the Southeastern Wisconsin Society of Anesthesiologists, and the Milwaukee County Society of Anesthesiologists. He also was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association. Surviving are his widow, Helen; a son, Dr S Michael, Philadelphia; and two daughters, Gail Phillips-Bloch, Fox Point, and Penny Corris of Whitefish Bay. ■

VIGNETTE BOOK

The Aesculapian Society, the historical arm of the SMS's Charitable, Educational and Scientific Foundation, invites all readers to contribute a story or two about a deceased Wisconsin physician to the Vignette Book Project.

The book is a collection of warm, human interest-type sketches of deceased Wisconsin physicians. It emphasizes the personality of the doctor, not just medical and educational accomplishments—the sort of thing that can be found in any standard, official biography. True, some of the sketches have biographical information in them, but the main theme is the personality of the man or woman.

So far, the Vignette Book has more than 60 sketches in it, representing 29 counties. A true picture of Wisconsin medical history is gathered together in the book, from the medical school researcher to the country practitioner. The Aesculapian Society needs your help in filling out the rest of the story.

During the summer, the Vignette Book is kept at the Fort Crawford Medical Museum in Prairie du Chien; in the winter time, it can be read at Society headquarters in the Council Room.

If a reader would like more information on the project, or would like to write a vignette, please contact: Mrs Deborah Erwin (Chesley), 826 North 75th Street, Wauwatosa, Wisconsin 53213.

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STATE MEDICAL SOCIETY OF WISCONSIN

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AUGUST 1 - 13, 1982

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The European Spectacular Tour is truly a "once-in-a-lifetime" opportunity! From Brussels to Cologne with its beautiful Cathedral—from the beauty of the Rhine River to the unviersity city of Heidelberg—from the Swiss cities of Lucerne and Geneva to elegant and fashionable Paris—this exciting tour has it all! Cities and countryside, mountains, and plains will delight you as you travel through some of the most beautiful areas in Europe. The variety of language, tradition, cuisine, artwork, and architecture will astound you—such a small area and so much variety!

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LET THESE GUIDES HELP YOU

THE FOLLOWING GUIDES and manuals have been prepared or obtained at the direction of the Board of Directors and/or commissions and committees of the State Medical Society of Wisconsin to be of direct personal assistance to the physician or his county medical society. Each is available (some without cost, others at nominal cost) upon request to the Communications Dept., State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

- **Interprofessional Code (1977 Revision)**—An instrument for better understanding between attorneys and physicians with reference to medical testimony and interprofessional conduct and practices.
- **Communications Guide for Wisconsin Hospitals and Physicians**—Establishes a communications guide for Wisconsin hospitals and physicians to promote cooperation between the allied medical professions and those who report medical news.
- **Comments on Fee Splitting Statute, Including Chapter 82, Laws of Wisconsin, 1973**—Governing physicians and others and authorizing employment of physicians by hospitals and others.
- **Approved Program in Continuing Medical Education**—Explains the State Medical Society of Wisconsin's accreditation program for continuing medical education in conjunction with the American Medical Association's Council on Medical Education.
- **Physician Guidelines: Blood-Alcohol Testing**—Includes a request/consent form for drawing blood. (Revised 1978—Single copy 25¢ with order.)
- **If You Have a Complaint About Medical Care**—Medical care is a personal matter between patient and physician. Yet, sometimes misunderstandings arise about what the physician hopes to accomplish and what the patient expects. This brochure, aimed at patients, explains the State Medical Society's grievance and peer review system.
- **School Health Examination**—A guide for physicians and school authorities in establishing a program of school health examinations. (Single copy $1.00 with order.)
- **Occupational Health Guide**—For medical and nursing personnel. A practical manual covering everything from "abnormal injuries" to "wounds," with every item suggesting steps to be taken, and providing space for specific instructions of the plant physician. Over 70 pages of instructional material, with all sections provided as separate sheets, punched to fit a ring book 10″x11½″. For handy reference order ring book, with full set of inserts, including anatomical charts. (Complete guide including ring binder: $11.00; complete guide without binder: $10.00—to accompany order.)
- **Make Yours a Smokeless Pregnancy**—Points out the dangers of smoking during pregnancy and its effects on the fetus.
- **Guide to the Service Corporation Law**
- **Retention and inspection of patients' records**—Explains the right of access to physician and hospital records concerning patient care, and includes the revised form, through statute amendment, of an *Interpretation* of Chapter 301, Laws of 1959.
- **Legal Responsibilities of the Physician-Patient Relationship**
- **Report of the Chiropractic Study Committee to the Governor's Health Planning and Policy Task Force**—Recommendations in this report were adopted by the Governor's Health Planning and Policy Task Force, October 23, 1972.
- **A Scientific Test of the Chiropractic Theory**—The first experimental study of the basis of the theory demonstrates that it is erroneous. Written by Edmund S. Crelin and reprinted by permission of *American Scientist.*
- **Some Straight 'Dope' on Marijuana**—Increasing evidence appearing regularly that marijuana is hazardous to health has led the State Medical Society of Wisconsin to declare it to be a dangerous drug. This brochure explains what marijuana is, who uses it, and points out some of the psychological and physiological hazards associated with its use.
- **Rubella—Red Measles Brochure**—This conveniently sized 2½″x4″ sized brochure alerts women to the necessity of being immunized for Rubella before they become pregnant. The brochure also reminds parents to have their children immunized for the red measles. Perfect for patient billing statements or waiting rooms.
- **To Your Good Health**—Explains the reasons behind rising health care costs and offers tips on how to save money on medical expenses.
- **Alcohol and Your Unborn Baby . . .**—Warns women of the harmful effects alcohol can have on an unborn child. Available in both English and Spanish versions.
- **To All My Patients, Partners in Good Health**—Explains the rights and responsibilities physicians and patients have in medical care. Available in standard brochure or smaller "statement stuffer" form.
- **I Want To Know What You Think**—a questionnaire physicians can use with patients to elicit their attitudes and opinions regarding his/her medical practice.
- **So You've Been Sued . . . Now What?**—a brochure prepared by the SMS Medical Liability Committee which answers 12 questions physicians commonly ask about medical malpractice lawsuits.

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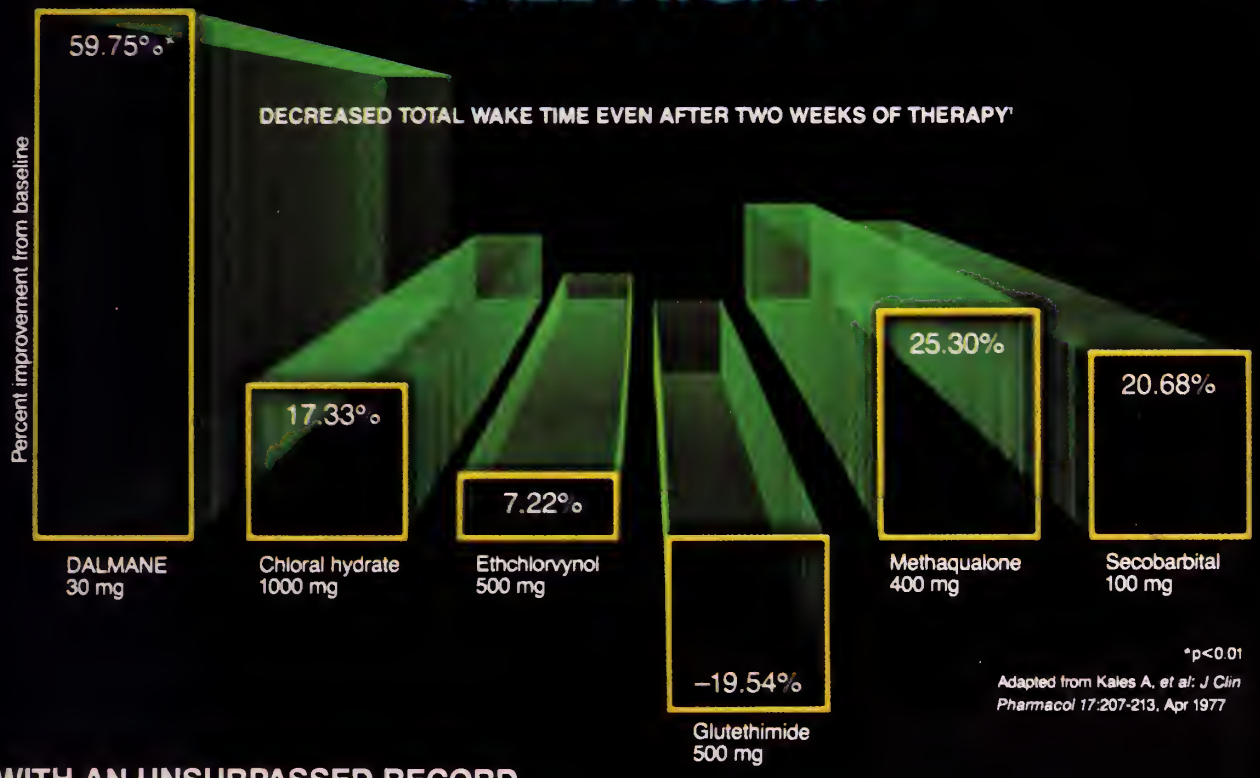

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- Well tolerated[2]
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UNLIKE NONSPECIFIC MEDICATIONS USED FOR SLEEP

Tricyclic antidepressants

–which are *not* sleep specific,[9] yet are sometimes used in nondepressed patients for sleep

–which can cause transient insomnia in the elderly[10]

–which can require careful monitoring in cardiovascular patients[10]

–which have strong anticholinergic effects[10]

Antihistamines

–which are *not* reliable sleep-inducing agents[11]

–which may produce stimulation instead[11]

–which have anticholinergic effects[11]

Major tranquilizers

–whose side effects may be troublesome for nonpsychotic patients[12]

–where tolerance for sedation appears rapidly[12]

Dalmane does not cause significant worsening of sleep beyond baseline levels upon discontinuation.[4]

References: **1.** Kales A. *et al J Clin Pharmacol 17* 207-213, Apr 1977 **2.** Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ **3.** Greenblatt DJ, Allen MD, Shader RI *Clin Pharmacol Ther 21* 355-361, Mar 1977 **4.** Kales A. *et al Clin Pharmacol Ther 18* 356-363, Sep 1975 **5.** Moore JD, Weissman L *J Clin Pharmacol 16* 241-244 May-Jun 1976 **6.** Spiegel HE Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ **7.** Robinson DS, Amidon EL Interaction of benzodiazepines with warfarin in man, in *The Benzodiazepines*, edited by Garattini S, Mussini E, Randall LO New York, Raven Press, 1973, pp 641-646 **8.** Warfarin Study Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ **9.** Baldessarini RJ Drugs and the treatment of psychiatric disorders, chap 19, in Goodman and Gilman's *The Pharmacological Basis of Therapeutics*, ed 6 New York, Macmillan Publishing Co Inc 1980, pp 391-447 **10.** Cole JO, Davis JM. Antidepressant drugs, chap. 31.2 in *Comprehensive Textbook of Psychiatry II*, edited by Freedman AM, Kaplan HI, Sadock BJ, ed 2 Baltimore The Williams & Wilkins Company, vol 2, 1976, pp 1941-1956 **11.** Douglas WW Histamine and 5-hydroxytryptamine (serotonin) and their antagonists, chap 26, in Goodman and Gilman's *The Pharmacological Basis of Therapeutics*, ed 6, New York, Macmillan Publishing Co Inc., 1980, pp 609-646 **12.** Davis JM, Cole JO Antipsychotic drugs, chap 31.1 in *Comprehensive Textbook of Psychiatry II*, edited by Freedman AM, Kaplan HI, Sadock BJ, ed 2 Baltimore, The Williams & Wilkins Company, vol 2, 1976, pp 1921-1940

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect.
Adults: 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients*: 15 mg recommended initially until response is determined.

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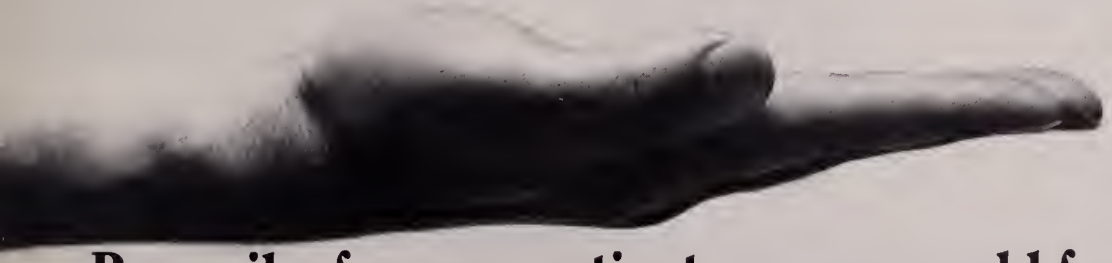

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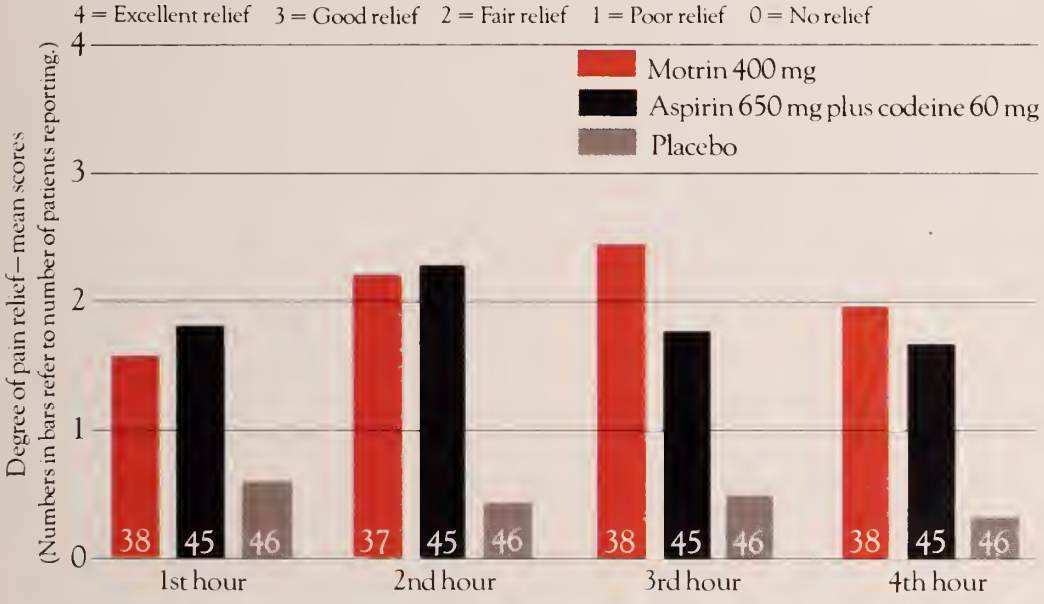
Comparison of pain relief
Motrin vs aspirin-codeine combination



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For relief of mild to moderate pain:

Motrin® 400 mg TABLETS
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• Not a narcotic • Not addictive • Not habit forming • Nonscheduled • Acts peripherally • Relieves pain rapidly • Relieves inflammation • Indicated in acute and chronic pain • Well tolerated (The most common side effect with *Motrin* is mild gastrointestinal disturbance.)

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Motrin® Tablets (ibuprofen, Upjohn)

Indications and Usage: Relief of mild to moderate pain.

Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. *Aspirin:* Used concomitantly may decrease Motrin blood levels. *Coumarin:* Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy nor by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin is gastrointestinal (4% to 16%). This includes nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness,* headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Rheumatoid arthritis and osteoarthritis, including flares of chronic disease: Suggested dosage is 300, 400, or 600 mg t.i.d. or q.i.d. Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain.

Do not exceed 2400 mg per day.

Caution: Federal law prohibits dispensing without prescription.

For additional product information, see your Upjohn representative or consult the package insert.

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MARCH 1981

It's time we took arthritis seriously.

It's a myth that arthritis is just the minor aches and pains of old age. It's a major crippler that attacks. Anybody. Anytime. 31 million Americans have it. There are almost a million new cases a year. And six out of ten are under 60. Symptoms can come and go for years. So if you don't know the warning signals, find out. If you'd like information that could help you—or you'd like to help us—write to the Arthritis Foundation, Box 19000, Atlanta, GA 30326.

ARTHRITIS FOUNDATION

Medical Yellow Pages

RATES: 40¢ per word, with a minimum charge of $16.00 per ad. BOXED AD RATES: $32.00 per column inch. DEADLINE: Copy must be received by the 20th of the month preceding month of issue; e.g., copy for the August issue is due July 20. Send copy to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 800/362-9080.

Physicians Exchange

Small-time specialty group (13) Door County, Wisconsin, needs to replace retiring OB-GYN. Write John Turk, Admin, Door County Medical Center, Sturgeon Bay, Wis 54235; ph 414/743-7261. 2-4/82

OB/GYN Specialists. Enjoy the security of group practice with the freedom of independent practice. If you are Board Certified or Board Eligible in OB/GYN, we have an interesting opportunity for you. Two specialists are needed immediately to form an independent OB/GYN practice in a very desirable Northern Wisconsin community with a drawing population of 70,000. Active practice assured. All major specialists available for consultation. Business and technical advice will be provided. Outstanding personal benefit programs available. Good income potential. New 35 million dollar hospital. For further information write: Administrator, PO Box 1646, Wausau, Wisconsin 54401. 2-4/82

Emergency Department physicians needed. Join rapidly expanding physician-owned group. Directorship available for qualified physician. Requires living in small community close enough to enjoy Madison advantages. Other opportunities available for full-time and part-time positions. Contact Bill Stafford, Mid-American Medical Services, SC, 1846 Hoffman Street, Suite 101, Madison, Wis 53704, or telephone 608/244-5555, or by WATS 1-800-362-7366. 2/82

Family Practitioners to work in community clinics near Madison, Wisconsin. Combination of a community office practice with privileges at major Madison hospitals. Family practitioner will join an already established internist to continue the growth of a medical practice, expand a small pediatric practice, and begin an obstetrical practice. Clinics are full service and have professional personnel support. Physicians have a guaranteed compensation package and an option to purchase the clinic from the community. Please send resume to T Arnfelt, Madison General Hospital, 202 South Park St, Madison, Wis 53715. 1-2/82

Physician wanted to share fully equipped medical office, x-ray, lab, fully staffed, small community, northern Wisconsin. Contact Dept 496 in care of the Journal. 12/81; 1-3/82

PRIMARY CARE PHYSICIANS
BOARD CERTIFIED OR ELIGIBLE

We represent over 50 communities throughout the state which are seeking quality primary care physicians. These communities offer established service areas, generous practice and financial arrangements.

CONTACT
Laurie Glowac or Fred Moskol
New Physicians for Wisconsin
University of Wisconsin Department of Family Medicine
777 South Mills Street, Madison, Wisconsin 53715
Phone: 608/263-4095
1-12/82

Green Bay, Wisconsin. Well established fee-for-service group in regional trauma/poison center seeks additional physician. $35,000 plus annual visits. Competitive salary with paid liability, CME, pension/profit sharing. Excellent recreational and educational opportunities. Great place to raise a family. Send CV to: A W Haines, MD, 435 Shady Drive, Oneida, WI 54155; ph 414/865-7740. 1tfn/82

Physician wanted to perform light physicals on a full or part-time basis. Ideal job for retiring physician. Contact Mike Stough collect at 513/621-8728. 10 tfn/81

The Racine Medical Clinic, a progressive cluster corporation of 25 physicians, is currently seeking an orthopedic surgeon and an invasive cardiologist. Full benefits, unlimited earnings and a full and exciting practice are offered. Please contact: Roger D Lacock, Administrator, Racine Medical Clinic, 5625 Washington Ave, Racine, WI 53406; ph 414/886-5000. 1tfn/82

Family physician, Board Certified or Eligible, to join four-man family practice group in northwest Wisconsin. First-year guaranteed salary. New clinic building located adjacent to 46-bed hospital, in the heart of Wisconsin's vacationland. Call shared with other family practice physicians in area, weekend coverage contracted. Jeanne Chamberlain, Adm, Spooner Clinic Ltd, 707 Ash St, Spooner, Wis 54801. Ph 715/635-2151. 12/81; 1-5/82

Fond du Lac—26 physician incorporated multispecialty group on the south shore of Lake Winnebago needs a fourth pediatrician. Guaranteed salary with full shareholder status available after one year. Send CV to Kirk A Veit, MD, 80 Sheboygan St, Fond du Lac, Wis 54935. 9tfn/81

Pediatric, Family Practice positions available in 13-member multispecialty group. Inquire: General Clinic of West Bend, Inc, 279 S 17th Ave, West Bend, Wis 53095. 2tfn/82

University Health Service: Gynecologist or generalist for women's health program, willing to work in team approach. Routine gynecological care, family planning services, health education, supervising nurse practitioners. Board-certification preferred. Illinois license or eligibility for license by time of appointment. Campus of 25,000, 1-1/2 hours from downtown Chicago. Position available immediately. For further information and application contact Director, University Health Service, Northern Illinois University, DeKalb, Ill 60115; ph 815/753-1311. Equal opportunity/Affirmative Action employer. 2-3/82

Surgeon with Thoracic general vascular training and Ophthalmologist to join a progressive multispecialty group of 17 physicians consisting of General/Family Medicine, General Surgery, Internal Medicine, OB-GYN, Ophthalmology, Orthopaedic Surgeon, Pediatrics/Adolescent Medicine, and Radiology. Subspecialties include: Pathology, Vascular Surgery, Cardiovascular Diseases, Gastroenterology and Endoscopy. We are located in a fast growing, scenic, lake country area between Milwaukee and Madison and can offer excellent hospital, schools and recreational facilities. Full fringe benefit package. Contact: James F Dowd, Admin, Wilkinson Clinic, SC, 915 East Summit Ave, Oconomowoc, Wis 53066; ph 414/567-4433. 9tfn/81

Physicians Exchange

continued

Wausau Medical Center, SC, a 50-physician multispecialty group has openings for physicians in the following specialties. *Family Practice, Hematology/Oncology, Neurology* and *Otolaryngology.* Competitive first-year salary, incentive plan thereafter. Comprehensive fringe benefits. New facility near new hospital. Located in beautiful, quiet, central Wisconsin, metropolitan area of 65,000. Recreational opportunities abundant. For more information contact: K L Day, MD, Wausau Medical Center, SC, 2727 Plaza Drive, Wausau, Wis 54401, or call collect 715/847-3351. 7tfn/81

Fifty physician multispecialty clinic in West Central Wisconsin wants cardiologist (non-invasive), neonatologist, neurologist, neurosurgeon, orthopedic surgeon, and otolaryngologist. Excellent cultural, educational, and recreational facilities. 90 miles from Minneapolis. Please contact James R Jepson, Administrator, Midelfort Clinic, Ltd, 733 West Clairemont Ave, Eau Claire, Wis 54702 or call (715) 839-5266. 1-3/82

Two Family Practice Physicians sought to assume a fully operational practice in a community 30 miles north of Madison, Wisconsin. New clinic facility. Income guaranteed. Physician back-up available. Board certified or eligible preferred. Contact John P Rahm, MD, 6105 Ridgewood Ave, Madison, Wis 53716. 5tfn/81

Wanted: Locum tenens physician to do FP and primary care. INTERHEALTH, phone 612/474-4372. 2/82

Medical Ophthalmologist wanted to join established, growing practice in beautiful Lake Tahoe-Reno, Nevada area. Excellent climate and year-round recreational facilities. Will consider full or part-time or retired physician. Contact Karen Grodowitz, MS, Executive Director, Reno Eye Clinic, 1530 E 6th St, Reno, Nev 89512; ph 702/329-1389. 10 tfn/81

Faculty Member Family Practice Program. The Black Hawk Area Medical Education Foundation is recruiting a Board Certified Family Physician to join its Family Practice Residency Program in Waterloo, Iowa. The program is community-based, affiliated with the University of Iowa College of Medicine, and part of the Iowa Network of Family Practice Residency Programs. The Waterloo metropolitan area has 125,000 people, four hospitals, and is well represented in the medical specialties. Applicants should have a MD degree, be eligible for licensure in Iowa, and should have several years of practice experience. Major duties include teaching residents in all aspects of patient care, including obstetrics, and also providing patient care. Other duties include some program administration and assisting in research from time to time. A salary in the range of $60,000 per year with an additional 20% fringe benefit package is offered. Other fringe benefits relating to retirement, moving expenses, and continuing education are provided. Please submit your resume to: Charles A Waterbury, MD, Program Director, Black Hawk Area Medical Education Foundation, 441 East San Marnan Dr, Waterloo, Iowa 50702; ph (319) 234-4419. Equal Opportunity Employer. 1-4/82

PUT EXPERIENCE TO WORK FOR YOU WHILE YOU SEARCH FOR A NEW CHALLENGE

Let years of experience as a healthcare professional and a Placement Counselor assist you in finding a new location with a new challenge. Physicians in all specialties are urgently needed throughout the country. Many types of situations available. Confidentiality assured.

Contact Donna Herschleb, RN
MEDICAL PROFESSIONAL PLACEMENTS
5222 Painted Post Drive, Madison, Wisconsin 53716
Phone: (608) 222-2927 *Licensed Employment Agency*

Immediate opening for General and Child Psychiatrist to join well-established clinic in a community of 50,000. Large referral area. Two excellent hospitals. University and industrial area. Salary open. Excellent benefits. Contact: J M Tobin, MD, Northwest Psychiatric Clinic, Box 224, Eau Claire, Wis 54701; ph 715/834-2751. 12/81; 1-3/82

Family Practice and Urology positions available with an 18-member multispecialty group corporate practice. Modern clinic facility in Northeastern Wisconsin city of 100,000 enjoying a healthy and stable economy. Excellent recreational, educational, hospital, civic advantages. Please call collect or write: W J Mommaerts, Clinic Manager, West Side Clinic, SC, 1551 Dousman St, Green Bay, WI 54303; ph 414/494-5611. 1-4/82

Fifty-physician, multi-specialty clinic in west central Wisconsin wants neonatologist, neurologist, neurosurgeon, orthopedic surgeon, and otolaryngologist. Excellent cultural, educational, and recreational facilities. 90 miles from Minneapolis. Please contact James R Jepson, Administrator, Midelfort Clinic, Ltd, 733 West Clairemont Ave, Eau Claire, Wis 54702; or call 715/839-5266. 2-4/82

Anesthesiologist, Board certified, to join a 250-bed community hospital in southeastern Wisconsin as its Director of Anesthesiology. Send curriculum vitae to Dept 498 in care of the Journal. 2-3/82

Doctors needed in Wisconsin and Minnesota, all specialties, all locations. For confidential information, mail your CV to Medicus, W62 N281 Washington Ave, Cedarburg, Wis 53012. 2tfn/82

Wanted. Board certified or eligible orthopedic surgeon to practice in conjunction with a 5-member surgery department in a 22-member multispecialty group. Present surgical specialties: thoracic and vascular surgery, general surgery and urology. The group is located in the upper midwest, in a city of 100,000 between two major metropolitan areas of greater than one million. If interested, please send CV to: Stephen Wagner, Kurten Medical Group, SC, 2405 Northwestern Ave, Racine, Wis 53404. All inquiries will be kept confidential. 12tfn/80

Internist/Generalist/Family Practitioner: Position available in 300-bed active psychiatric rural hospital. Fully JCAH accredited. Three-year Psychiatric Residency Program. All treatment modalities. Numerous affiliated educational programs. Near metropolitan and recreational areas. Relaxed, low crime, low turmoil area. Salary range $47,902-$58,282 depending upon qualifications. Good fringe package and possibility of some private practice. Position involves directing a 15-bed medical-surgical unit and provide consultation to psychiatric staff. Contact Superintendent, Mental Health Institute, Independence, Iowa 50644; ph 319/334-2583. Equal Opportunity Employer. 12/81; 1-2/82

Grow with us in the Sunbelt. The INA Healthplan needs physicians in family practice and most specialties in Miami, Tampa, Dallas, Phoenix, Tucson, and Los Angeles. Attractive salaries and comprehensive benefits including professional development, retirement, and profit sharing programs are provided. If team interaction and casual living interest you, send a brief CV to Medical Administration, INA Healthplan, Inc, 7616 LBJ Freeway, Suite 303, Dallas, Tex 75251. 12/81; 1-2/82

General Surgeon. Board eligible/certified to join primary care group of six family physicians. Well established, rural setting, preceptor University of Wisconsin, JCAH 70-bed hospital. Send CV to: Gary Petersen, MD, Krohn Clinic, Ltd, 610 W Adams St, Black River Falls, Wis 54615. 10 tfn/81

Dermatologist, Rheumatologist needed to join multispecialty group of 33 physicians dedicated to primary care in East Central Wisconsin community. City population 48,000, drawing area 100,000. Attractive income arrangements, association membership possible after one year, pension and profit sharing, extensive fringe benefits. Contact: R B Windsor, MD, 1011 North 8th St, Sheboygan, Wis 53081; ph 414/457-4461. 12tfn/81

Medical Facilities

Port Washington, Wisconsin. New prime office space in professional building. Upper level already occupied by three internists (specializing in cardiology), one dentist, and three doctors of chiropractic. Lower level has 700-2500 sq ft. Area needs obstetrician-gynecologist, pediatricians, urologist, dermatologist, and general practitioner. X-ray machines and equipment possible. Twenty miles north of Milwaukee. Phone 414/375-3010 or 414/284-0500 or write 1032 S Spring St, Port Washington, Wis 53074. 2-3/82

For Sale. Williams Bay, Wis. Well equipped medical practice in a beautiful resort area near Lake Geneva, Wis. Three examining rooms, one consulting room, one business office, large reception area, and lab facilities. To take over four more years on present lease. The only medical practitioner in the village; suitable for solo or partnership. Present practice is general with orientation to family, seeing between 15 and 20 patients per day. Flexible terms. For information write to: Rajesh Alwa, Box 938, Williams Bay, Wis 53191; or call 414/245-5566. 2/82

Palm Springs, CA. Large medical practice located in center of the fastest growing US resort/retirement area. 1980 gross $600,000 +. Perfect for one or more physicians or physicians-investor group. Full information regarding this complete medical facility upon request. Desert Medical Center, 43-576 Washington St, Palm Desert, CA 92260; ph 714/345-2696. p2/82

Office Space For Rent. Three examining rooms, one x-ray room, and waiting room in medical clinic in a town of 3000. This clinic formerly provided a very strong practice for two family practitioners for 15 years. The village of Sturtevant is located three miles from a new major medical center. Just south of Milwaukee and near Lake Michigan where fishing and sailing is just minutes away. Also, inland lake living is within seven miles of here. One or two physicians interested in a long term commitment will find the lease terms to be *very* reasonable and land is available to add on to or to remodel the present clinic area. Contact Ronald E Schroeder, 8700 Racine Ave, Sturtevant, Wis 53177; ph 414/886-4178. 2-4/82

Green Bay, Wisconsin new prime office space across from new St Mary's Hospital. Lease or purchase options. Dr J Van Miller, phone 414/499-4241. 12tfn/79

Family Practice. Established, independent practice in equipped office. Small city in recreational area. Continued care of patients main interest. Contact: KL Haman, MD, 199 South Division, Waupaca, Wis 54981; ph 715/258-2707. 11tfn/81

Immediate solo practice available in Jefferson, Wisconsin, due to the recent death of Richard H Siedenburg, MD. Expandable building with three large lots available. Lease or purchase. Contact Miller Law Office, PO Box 417, Jefferson, Wisconsin 53549; ph 414/674-3345. g11tfn/81

Prime east Madison medical office space to share. 2000 sq ft. Fully equipped and well furnished. Private office and sound proof examining rooms. X-ray, lab, and physical therapy facility on premises. Equipped minor surgery room. Share rent and staff expenses on a 50-50 basis or prorated to your needs. For more information and appointment to view facility, call C A Genchcff, DO: 608/241-3451. 12/81-1/82*

Miscellaneous

Physician's Assistant seeks relocation. Have national-Wisconsin state certification. Experience in rural primary care and general surgery. Prefer small community or rural family practice in Southeastern Wisconsin. Resume and references upon request. Contact Dept 494 in care of the Journal. 9tfn/81

Author's editor. Technical assistance for your manuscripts and medical writing. K M Lopate, Picas Anon, 235 N Eastmoor, Brookfield, Wis 53005; ph 414/786-3922. 1tfn/82

Medical student graduating 1986 looking for financial support prior to entry into rural family practice in Wisconsin. James Schoening, 21425 Spring St, Room 130 Atherton Hall, Union Grove, Wis 53182; ph 414/878-4504. 2/82

Real Estate

For Sale. Cottage. Wild Rose, Wisconsin. South-facing with 150 feet lake frontage on one of the best fishing lakes in the area. Front deck offers the best view on the lake. Surrounded by woods. Some of the best hunting and fishing in state, and a good ski hill 5 minutes away. Call 612/894-6076. 12tfn/81

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Meetings/CME Courses

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates: 40¢ per word, with a minimum charge of $16.00 per listing. BOXED LISTINGS: $32.00 per column inch. COPY DEADLINE for Continuing Medical Education listings is tenth of the month preceding the month of publication; e.g., copy for the August issue is due by July 10. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 800/362-9080. For listing of other meetings see the Special issue of the Journal of the American Medical Association: Continuing Education Courses for Physicians for period Sept 1, 1981 through Aug 31, 1982.

WISCONSIN

MARCH 1-5, 1982: *Cardiac Rehabilitation Workshop,* La Crosse. See details elsewhere in this section.

MARCH 4-5, 1982: *First Annual Symposium on Chronic Obstructive Pulmonary Diseases,* Madison. Sponsored by Continuing Medical Education, Health and Human Services Area, University of Wisconsin-Extension; the Pulmonary Section, School of Medicine; and the Department of Nursing, University of Wisconsin, Madison; and the Respiratory Therapy Department, Center for Trauma and Life Support, Center for Health Sciences, University of Wisconsin, Madison. Thirteen credit hours Category I of AMA; AOA, Wisconsin Nurses Association and Family Practice credit applied for; University of Wisconsin-Extension 1.3 CEUs. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

MARCH 16, 1982: Milwaukee Academy of Medicine program—*Some Favorite JAMA Covers,* by Therese Southgate, MD, Deputy Editor, JAMA, Chicago, IL. Info: Milwaukee Academy of Medicine, PO Box 26509, 8701 Watertown Plank Road, Milwaukee, WI 53226 (phone 414/257-8249).

MARCH 20, 1982: *New Developments in Limb Prosthetics and Spinal Orthotics,* by Ram P Bhala, MD FACP, Milwaukee, sponsored by St Luke's Hospital. Approved for 7 credit hours for Category I of AMA-PRA and 7 prescribed credit hours by AAFP. Info: Penny Zoltak, St Luke's Hospital, 2900 W Oklahoma Ave, Milwaukee, Wis 53215; ph 414/647-6806.

STATE MEDICAL SOCIETY OF WISCONSIN
Dates and Locations of Annual Meetings
1982-1992

All meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) and the new Hyatt Regency as the headquarters hotel with the exception of 1985, when the meeting will be held at the LaCrosse Convention Center.

1982—May 13-15	**1987—Mar 26-28**
1983—Mar 24-26	**1988—Apr 28-30**
1984—Mar 29-31	**1989—Apr 13-15**
1985—Apr 25-27	**1990—Apr 26-28**
1986—Apr 17-19	**1991—Apr 18-20**
	1992—Apr 23-25

Meeting days will be Thursday and Friday; the first session of the House of Delegates will convene on Thursday, the second and third on Friday. Scientific programming will be on Friday and Saturday.

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701. Local telephone: 257-6781; toll-free in Wisconsin: 1-800/362-9080.

MARCH 25-26, 1982: *6th Annual Ophthalmology Current Concepts Seminar '82,* at Inn on the Park Hotel, Madison. Sponsored by University of Wisconsin, School of Medicine, Dept of Ophthalmology; and University of Wisconsin-Extension, Dept of Continuing Medical Education. Credit applied for Category I of AMA-PRA. Fee: $155. Info: Sarah Z Aslakson, Continuing Medical Education, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

APRIL 2-3, 1982: *Advances in Emergency and Cardiovascular Critical Care,* Sheraton Inn, Madison. Sponsored by the Methodist Hospital and the Jackson Clinic. Info: Mark Olsky, MD, Director, Emergency Services, Methodist Hospital, 309 W Washington Ave, Madison, Wis 53703; ph 608/251-2371.

APRIL 14-16, 1982: Third Annual Madison Clinic Conference, *Therapeutic Management of Cardiovascular Diseases.* Sponsored by Extension Services in Pharmacy and the School of Pharmacy, University of Wisconsin, Madison. Info: Alan L Hanson, PhD, Extension Services in Pharmacy, School of Pharmacy, 425 N Charter St, Madison, Wis 53706; ph 608/262-3130.

APRIL 16-17, 1982: *Second Annual General Surgery Conference: Breast and Endocrine Disease,* University of Wisconsin Clinical Science Center, Madison. Sponsored by University of Wisconsin Dept of Surgery, University of Wisconsin-Extension Dept of Continuing Medical Education. Approved 9 credit hours AMA Category I, UW Extension CEUs. Fee: $155 physicians; $100 residents, nurses, others. Info: Sarah Z Aslakson, Continuing Medical Education, 465B WARF Bldg, 610 Walnut St, Madison, WI 53706; ph 608/263-2856.

APRIL 19-23, 1982: *Cardiac Rehabilitation Workshop,* La Crosse. See details elsewhere in this section.

APRIL 20, 1982: Milwaukee Academy of Medicine program—*Clinimetrics: An Additional Basic Science for Clinical Medicine,* AOA Lecture, by Alvan Feinstein, MD, Professor of Medicine and Epidemiology, Yale University, New Haven, CT. Info: Milwaukee Academy of Medicine, PO Box 26509, 8701 Watertown Plank Road, Milwaukee, WI 53226 (phone 414/257-8249).

APRIL 27, 1982: Milwaukee Ophthalmological Society, University Club, 924 E Wells St, Milwaukee, Wis 53202. Speaker: Dr J A McCrary, Baylor College of Medicine. Dinner at 6:30 pm and meeting at 7:30 pm. Info: John Ridley MD, 2315 N Lake Dr, Seton Tower, #1001, Milwaukee, Wis 53211; ph 414/278-7500.

APRIL 28-30, 1982: *State of the Art-Radiologic Approaches to the Chest and Abdomen,* Madison. Sponsored by the Uni-

versity of Wisconsin-Extension; Dept of Continuing Medical Education; and University of Wisconsin, School of Medicine, Dept of Surgery. Approved 21 credit hours of Category I AMA and ACR. Info: Sarah Z Aslakson, Continuing Medical Education, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

MAY 5-7, 1982: *Fifth Annual Cardiac Rehabilitation Symposium,* Red Carpet Inn, Milwaukee. Sponsored by Mt Sinai Medical Center, Milwaukee; University of Wisconsin-Extension, Dept of Continuing Medical Education; American Heart Association, and American College of Sports Medicine. Approved 25 credit hours of Category I AMA; AOA Category 2-D, University of Wisconsin Continuing Education Units. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

MAY 6-7, 1982: *Trends in Radiologic Technology—1982,* Wisconsin Center, Madison. Sponsored by Allied Health Program Unit, UW-Extension; Dept of Radiology, School of Medicine, University of Wisconsin. ECE points applied for from ASRT, University of Wisconsin Continuing Education Units. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, WI 53706; ph 608/263-2856.

MAY 13-14, 1982: *8th National Conference on Case Resolution of Complex Industrially Injured,* Pioneer Inn, Oshkosh. Sponsored by Industrial Injury Clinic, University of Wisconsin-Extension, Continuing Medical Education, in cooperation with Theda Clark Regional Medical Center. AMA Category I, Continuing Legal Education credits, Commission on Rehabilitation Counselor Certification, University of Wisconsin Continuing Education units. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, WI 53706; ph 608/263-2856.

MAY 23-25, 1982: Wisconsin Chapter, American Academy of Pediatrics, Playboy Club, Lake Geneva.

JUNE 6-10, 1982: *Managing Health Care Resources in the Competitive Environment of the 1980s,* La Crosse. Sponsored by Western Wisconsin Health Systems Agency, University of Wisconsin Extension, and the University of Wisconsin La Crosse Business Outreach Department. Guest speakers include, Dr Alain Enthoven, Stanford University; Dr Erik Ritman, Mayo Medical School; and Dr Larry Cummings, Northwestern University. Info: Thomas M Lynch, Conference Director, Western Wisconsin Health Systems Agency, 1707 Main, La Crosse, WI 54601; ph 608/785-9352.

JUNE 7-11, 1982: *Cardiac Rehabilitation Workshop,* La Crosse. See details elsewhere in this section.

Cardiac Rehabilitation Workshops

Offered through the joint effort of the La Crosse Exercise Program and La Crosse Lutheran Hospital/Gundersen Clinic, Ltd, six times throughout the year as follows:

March 1-5	**June 7-11**	**July 12-16**
April 19-23	**June 14-18**	**Sept 20-24**

Workshops provide an indepth understanding and experience of all aspects of cardiac rehabilitation and a thorough understanding of the organizational and administrative aspects of a cardiac rehabilitation program. Workshops will consist of didactic lecture with structured laboratory experiences and examinations. Accreditation through a number of agencies is offered. For further information contact:

Dr Philip K Wilson, Workshop Unit-La Crosse Exercise Program, Mitchell Hall/University of Wisconsin-La Crosse, La Crosse, Wis 54601; phone 608/785-8686

JUNE 14-18, 1982: *Cardiac Rehabilitation Workshop,* La Crosse. See details elsewhere in this section.

JUNE 16-19, 1982: Annual Scientific Assembly of the Wisconsin Academy of Family Physicians, Radisson Hotel, La Crosse. Approved 20 credit hours Category I of AMA-PRA. Info: Robert H Herzog, Wisconsin Academy of Family Physicians, 850 Elm Grove Rd, Elm Grove, Wis 53122; ph 414/784-3656.

JUNE 17-23, 1982: *Fifteenth Annual Postgraduate Course in Gynecological Pathology, Cytogenetics and Endocrinology,* Pfister Hotel and Tower, Milwaukee. Sponsored by The Medical

WISCONSIN SPECIALTY SOCIETY MEETINGS: 1982

Wisconsin Society of Radiation Oncologists, Feb 20, 1982, Olympia, Oconomowoc

Wisconsin Psychiatric Association, Feb 25-28, 1982, Lake Lawn Lodge, Lake Delavan

Wisconsin Dermatological Society, Feb 27, 1982, UW Center for Health Sciences, Madison

Wisconsin Urological Society, Apr 30-May 1, 1982, Concourse Hotel, Madison

Wisconsin Chapter: American Academy of Pediatrics, May 23-25, 1982, Playboy Club, Lake Geneva

Wisconsin Academy of Family Physicians, June 17-20, 1982, Radisson Hotel, La Crosse

Wisconsin Society of Obstetrics & Gynecology, July 23-24, 1982, Leathem Smith Lodge, Sturgeon Bay

Wisconsin Neurological Society, Fall (September ?) 1982

Wisconsin Surgical Society, Sept 9-10, 1982, Holiday Inn and/or Radisson Hotel, La Crosse

Wisconsin Society of Internal Medicine, Sept 9-11, 1982, Holiday Inn (Downtown), Green Bay

Wisconsin Society of Anesthesiologists, Sept 9-12, 1982, Concourse Hotel, Madison

Wisconsin Radiological Society, Oct 16, 1982 Concourse Hotel, Madison

Wisconsin Allergy Society, Oct 17-18, 1982, Pioneer Inn, Oshkosh

Wisconsin Chapter: American College of Emergency Medicine, October 1982, The Pfister Hotel & Tower, Milwaukee

* * *

SPECIALTY SOCIETY MEETINGS TO BE HELD IN CONJUNCTION WITH SMS ANNUAL MEETING, May 13-15, 1982, Milwaukee

Wisconsin Allergy Society
Wisconsin Orthopaedic Society
Wisconsin Society of Internal Medicine
Wisconsin Society of Pathologists
Wisconsin Society of Physical Medicine and Rehabilitation
Wisconsin Society of Plastic Surgeons
Wisconsin Society for Preventive Medicine
Wisconsin Society of Radiation Oncologists
Wisconsin Surgical Society

College of Wisconsin, Milwaukee. Fee: $500 enrollment fee will include 68 selected 35mm slides. Approved 42 credit hours of Category 1 of AMA-PRA and AAFP. Info: Richard F Mattingly, MD, Medical College of Wisconsin, 8700 West Wisconsin Ave, Milwaukee, Wis 53226.

JUNE 24-25, 1982: *Obstetrical Events and Neonatal Brain Injury,* Wisconsin Center, Madison. Sponsored by Continuing Medical Education, Health Sciences Unit, University of Wisconsin-Extension and Departments of Family medicine and Practice, Pediatrics, Gynecology and Obstetrics, School of Medicine, University of Wiconsin, Madison, and Madison General Hospital and St Marys Hospital Medical Center. Twelve credit hours, AMA; AOA; CEU's ACOG applied for. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

JULY 12-16, 1982: *Cardiac Rehabilitation Workshop,* La Crosse. See details elsewhere in this section.

AUGUST 6-8, 1982: Wisconsin Dermatological Society summer meeting, Lake Geneva, Wis. Info: Robert A McDonald, MD, 1313 Fish Hatchery Rd, Madison, Wis 53715.

SEPTEMBER 9-11, 1982: Wisconsin Society of Internal Medicine and American College of Physicians joint meeting, Holiday Inn Downtown, Green Bay. Info: Kim Marggraf, Wisconsin Society of Internal Medicine, 611 East Wells St, Milwaukee, Wis 53202.

SEPTEMBER 20-24, 1982: *Cardiac Rehabilitation Workshop,* La Crosse. See details elsewhere in this section.

OCTOBER 16, 1982: Wisconsin Radiological Society, Concourse Hotel, Madison.

OTHERS

January-July 1982 (Minnesota): *Continuing Medical Education* programs are listed in a box elsewhere in this section.

MARCH 12-14, 1982 (Illinois): *Midwest Clinical Conference,* at the Conrad Hilton, Chicago. Up to 20 hours Category I CME credit will be offered. Chicago Medical Society, along with major local specialty societies, is sponsoring event. Info: Dept of Education, Chicago Medical Society, 515 N Dearborn St, Chicago, IL 60610; ph 312/670-2550. g2/82

University of Minnesota
CONTINUING MEDICAL EDUCATION
January-July, 1982

Office Management in Ear, Nose & Throat: A Practical, Problem-Oriented Approach	Feb 26-27
Cardiopulmonary Medicine: 1982	Mar 4-6
Current Concepts in Perinatal Medicine	Mar 11-12
Recurrent Lung Disease in Childhood	Mar 26
Psychiatry for Primary Care Physicians	Apr 2
Correction of Aphakia (Annual Ophthalmology Course)	Apr 19-20
Allergy and Clinical Immunology	Apr 29-May 1
Tissue Specific Antigens: An International Conference	May 3-5
Human Aging V	May 5-6
Medical Directors Spring Meeting	May 7
Family Practice Review: Update 1982	May 10-14
Current Concepts in Radiation Therapy	May 19-21
Topics and Advances in Pediatrics	May 24-25
Biotechnology Symposium	May 26-28
Coronary Heart Disease Workshop	Jun 2-4
Management of Musculoskeletal Tumors (Annual Orthopaedic Surgery Conference)	Jun 9-11
Clinical Hypnosis	Jun 11-12
Advances in Vascular Surgery: 46th Annual Surgery Course	Jun 14-16
The Disabled Adolescent	Jun 29-30
Malnutrition: The Clinician's Role	Jul 9-10

Accreditation: All courses are approved for AMA/ACCME Category 1 credit and, as appropriate, by specialty societies.

For advance information and registration, write or call: Continuing Medical Education, University of Minnesota, Box 293 Mayo Memorial Bldg, 420 Delaware St, SE, Minneapolis, MN 55455; ph 612/373-8012. 1-3/82

MIDWEST Regional CME meetings
American College of Physicians

FEBRUARY 26-27, 1982 (Kansas): Hilton Inn, Wichita. Info: Max S Allen, MD, FACP, University of Kansas Medical Center, 39th St & Rainbow Blvd, Kansas City, KS 66112.

MARCH 26-27, 1982 (Nebraska): Hilton Hotel, Lincoln. Info: Bowen E Taylor, MD, FACP, Box 81009, Lincoln, NE 68501.

APRIL 29, 1982 (North Dakota): Westward Ho, Grand Forks. Info: Harold W Evans, MD, FACP 2624 Olson Dr, Grand Forks, ND 58201.

JUNE 4-5, 1982 (Iowa): University of Iowa, Iowa City. Info: William B Galbraith, MD, FACP, 115 8th St, NE, Cedar Rapids, IA 52401.

SEPTEMBER 9-11, 1982 (Wisconsin): Holiday Inn Downtown, Green Bay. Joint meeting with WSIM. Info: Kim Marggraf, Wisconsin Society of Internal Medicine, 611 East Wells St, Milwaukee, WI 53202.

1982 PAIN & STRESS MANAGEMENT WORKSHOPS

March 6 Vancouver, WA
March 19 Portland, OR
March 26 San Francisco, CA
March 30 Springfield, MO
May 7-9 Seattle, WA
May 13-15 Springfield, MO with 10 experts
June 11 Houston, TX
July 19 Stevens Point, WI
Nov 6-7 Milwaukee, WI

Write or Phone for Patient or Workshop Information

The Shealy Pain & Health Rehabilitation Center™
1919 South Fremont
Springfield, MO 65804

(608) 786-0611 p2/82

MARCH 13-20, 1982 (Mexico): *Seventeenth Annual Clinical Conference* of the Marquette-Medical College of Wisconsin Alumni Association, Camino Real Hotel, Ixtapa, Mexico. Approved 20 credit hours of Category 1 AMA-PRA. Info: Robert H Herzog, Marquette-MCW Medical Alumni Association, 8701 Watertown Plank Rd, Milwaukee, Wis 53226; ph 414/257-8367.

MARCH 15-19, 1982 (Louisiana): Twentieth National Conference on Breast Cancer, Hyatt Regency Hotel, New Orleans, La. Sponsored and arranged by the American College of Radiology; co-sponsored by the American Cancer Society; American Society of Therapeutic Radiologists; College of American Pathologists; The Plastic Surgery Educational Foundation, and The Society for the Study of Breast Disease. Fee: $350. Info: Breast Cancer Conference, American College of Radiology, 6900 Wisconsin Ave, Chevy Chase, MD 20815.

MARCH 20-25, 1981 (Hawaii): Spring Meeting of American Academy of Pediatrics, Honolulu. Info: AAP, 1801 Hinman Ave, PO Box 1034, Evanston, Ill 60204.

APRIL 4-6, 1982 (Mississippi): *National Conference on Rural Primary Care,* sponsored by National Rural Primary Care Association, at Jackson, MS. This fifth annual meeting provides a singular opportunity for rural health professionals to share insights and discuss problems with peers, while receiving continuing education credit for soundly developed work sessions. Info: National Rural Primary Care Association, Attn: Lane Fisher, Communications Coordinator, Box 1211, Waterville, ME 04901 (ph 207/873-1127).

APRIL 28-30, 1982 (Indiana): *Endocrinology and Diabetes for the General Internist,* Indianapolis. Info: Registrar, American College of Physicians, 4200 Pine St, Philadelphia, PA 19104.

MAY 16-20, 1982 (Brazil): *The Fifth International Symposium on the Prevention and Detection of Cancer, San Paulo, Brazil.* Sponsored by Fundacao "Centro de Pesquisda de Oncologia" and The International Society for Preventive Oncology; Info: Medical Congress Coordinators Department, 1212 Avenue of the Americas, New York, NY 10036; ph 212/840-0110. g8-12/81; 1-4/82

MAY 19-22, 1982 (Florida): *Twenty-second International Conference on Legal Medicine,* sponsored by American College of Legal Medicine, at Boca Raton Hotel and Club, Boca Raton. Info: American College of Legal Medicine, 875 North Michigan Ave, Suite 3744, Chicago IL 60611.

JUNE 2-4, 1982 (Illinois): *Problem Solving in Lung Disease: A Practical Approach,* Chicago. Info: Registrar, American College of Physicians, 4200 Pine St, Philadelphia, PA 19104.

JUNE 14-16, 1982 (Canada): *Critical Care Medicine-1982,* Banff, Alberta. Info: Registrar, American College of Physicians, 4200 Pine St, Philadelphia, PA 19104.

JUNE 17-19, 1982 (Texas): *Review of Internal Medicine-1982,* Houston. Info: Registrar, American College of Physicians, 4200 Pine St, Philadelphia, PA 19104.

JUNE 26-JULY 10, 1982 (Austria/Monaco): *XIIth World Congress on Sports Medicine* in Vienna, Austria June 26-July 4 and *Post Congress Symposium* in Monte Carlo, Monaco, July 4-10. "Practical Application of Sports Medicine for Physicians, Trainers, and Coaches." Contact PO Box 66, Shawnee Mission, Kansas 66201 or call 800-255-6969. 2-5/82*

JULY 29-AUGUST 1, 1982 (Illinois): *International Doctors in Alcoholics Anonymous, Annual Meeting.* Hotel reservations directly at Ramada the O'Hare Inn, 6600 N Mannheim Rd, Des Plaines, Ill 60018 or call 312/827-5131 or 800/288-2828. (Be sure to specify IDAA for special rates). Further information contact Secretary IDAA, 1950 Volney Rd, Youngstown, Ohio 44511; ph 216/782-6216. g2tfn/82

AMA

FEBRUARY 25-28, 1982: AMA National Leadership Conference, Downtown Chicago Marriott, Chicago, Ill.

JUNE 13-17, 1982: Annual AMA House of Delegates, Downtown Chicago Marriott, Chicago, Ill.

DECEMBER 5-8, 1982: Interim AMA House of Delegates, Miami Beach, Fl. ■

Bookshelf

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School and by others who are particularly qualified. Most books here listed will be available on loan from the Medical Library Service, 1305 Linden Drive, Madison, Wisconsin 53706; tel. 608/262-6594.

Goodbye Blues: Breaking the Tranquilizer Habit the Natural Way. By Bernard Green, PhD. 1981. McGraw-Hill Book Co, 1221 Avenue of the Americas, New York, New York 10020. Pp 173. Price: $10.95.

Harper's Review of Biochemistry. 18th edition. By David W Martin Jr, MD; Peter A Mayes, PhD, DSc; and Victor W Rodwell, PhD. 1981. Lange Medical Publications, Drawer L, Los Altos, Calif 94022. Pp 614. Price: $18.

Neuropsychiatric Features of Medical Disorders. By James W Jefferson, MD and John R Marshall, MD. 1981. Plenum Publishing Corp, 223 Spring St, New York, NY 10013. Pp 383. Price $24.50.

General Urology. 10th edition. By D R Smith, MD. 1981 Lange Medical Publications, Drawer L, Los Altos, Calif 94022. Pp 598. Price: $19.50.

Clinical Cardiology. By M Sokolow, MD and M B McIlroy, MD. 1981 Lange Medical Publications, Drawer L, Los Altos, Calif 94022. Pp 763. Price: $21.50.

American Board of Medical Specialties. Annual Report & Reference Handbook—1981. 1603 Orrington Ave, Evanston, Ill 60201. Pp 66.

Initial Report and Preliminary Recommendations, National Commission on Nursing. September 1981. The Hospital Research and Educational Trust, 840 N Lake Shore Drive, Chicago, Ill 60611. Pp 80.

Medical Choices Medical Chances. By Harold Bursztajn, MD; Richard I Feinbloom, MD; Robert M Hamm, PhD; Archie Brodsky. Delacorte Press/Semour Lawrence, 1 Dag Hammarskjold Plaza, New York, NY 10017. 1981. Pp 456. Price: $14.95. ■

News You Can Use

By EARL THAYER, Secretary / BERNIE MARONEY, Assistant Secretary

OVERCHARGES TO MDs TO RESULT IN $7.5 MILLION REFUND. If, over the past several years, you thought you were paying too much for medical malpractice insurance, it appears you were right. On December 9, 1981, the Board of Governors of the Wisconsin Health Care Liability Insurance Plan (WHCLIP) adopted a resolution which calls for refunding $7.5 million to WHCLIP insureds. After extensive analysis of WHCLIP's financial condition and claims experience, the Board determined that premiums charged in several years of WHCLIP's existence were excessive. As a result, the Board adopted the following resolution:

> **"Be it resolved that the Board herewith authorizes the payment no later than December 31, 1982, of refunds for excess premiums, including a portion of the earnings generated on such premiums, in the amount of $7.5 million."**

The Actuarial/Underwriting Committee is developing a formula for distribution of the refunds. Both the SMS Medical Liability Committee and Board of Directors monitor these developments very closely in attempts to assure that WHCLIP continues to be a financially sound and stable program.

MEDICAID CHANGES RULES ON NURSING HOME VISITS. Under a provision of the Reagan Administration's Omnibus Reconciliation Act, which became effective October 1, 1981, physicians' assistants and nurse practitioners under Medicaid (Title 19) may perform nursing home visits to recertify medical necessity. Physicians should note that this does not change Wisconsin requirements under H-32 (nursing home rules) that a physician must see all skilled-care patients every 30 days and intermediate-care patients every 60 days. Skilled-care patients may be extended to 60 days if they are receiving rehabilitative services and it is documented in the record that the physician feels the frequency is adequate. This change has no affect on Medicare (Title 18).

AMA PLANS PROGRAM OF WRITTEN PATIENT MEDICATION INSTRUCTIONS. The American Medical Association expects to have a program in operation by mid-year which will provide patients, through their physicians, with written information about prescription drugs. Initially, Patient Medication Instruction sheets (PMIs) will cover ten widely prescribed drugs. Eventually, as many as 200 medications are expected to be in the voluntary program. The program is intended to supplement the physician's oral instructions and enhance consumers' knowledge about the drugs they are taking. This action comes on the heels of an announcement by the Federal Food and Drug Administration that it plans to drop its pilot program requiring patient package inserts on ten prescription drugs. In making the announcement the FDA noted the acceleration of voluntary private sector efforts to assume responsibility for educating patients about drugs and referred to the AMA's program.

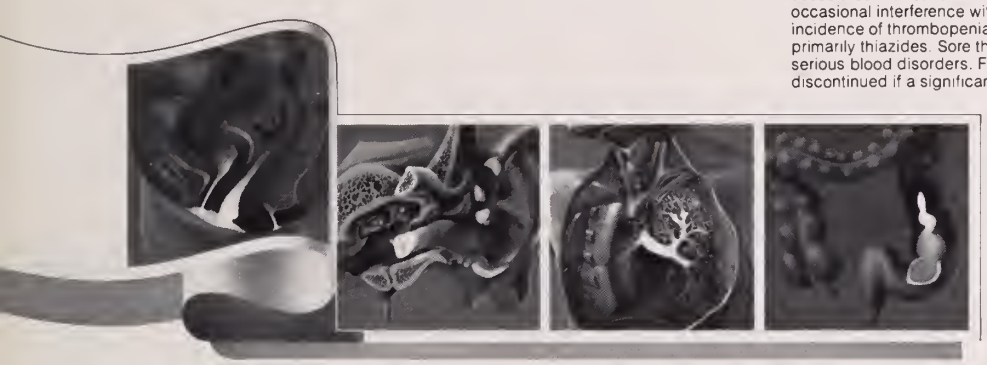
AMA LIBRARY: A READY REFERENCE FOR PHYSICIANS. The AMA Library, organized in 1911, is one of the oldest and most comprehensive national association libraries in the country. It is the focal point for handling inquiries received at AMA Headquarters. Among the many services the library offers is access to an international file of clinical and socioeconomic medical information through 140 computerized data bases. For more information on the services and publications available, request the free pamphlet from the Division of Library and Archival Services, AMA Headquarters, 535 N Dearborn, Chicago, IL 60610. ■

IF YOU WISH TO HELP AN IMPAIRED PHYSICIAN. The State Medical Society of Wisconsin's Impaired Physician Program wishes to identify, intervene, and bring about the rehabilitation of physicians impaired by use of alcohol and other drugs, or mental or physical infirmity. Persons may call 608/257-6781 or toll-free: 800/362-9080 and explain their concern to Mr John LaBissoniere or Mr H B Maroney of the Impaired Physician Program staff. The caller's identity will be kept in complete confidence.

Bactrim™
(trimethoprim and sulfamethoxazole)
succeeds

Bactrim is useful for the following infections when due to susceptible strains of indicated organisms (see indications section in summary of product information):

Expanding its usefulness in antimicrobial therapy



in recurrent UTI...
a continuing record of high clinical effectiveness against common uropathogens

in acute otitis media in children...
effective against both major otic pathogens...with *b.i.d.* convenience

in acute exacerbations of chronic bronchitis in adults...
clears the sputum and lowers its volume...on *b.i.d.* dosage

in shigellosis...
faster relief of diarrhea than with ampicillin[2]

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. Limited clinical information presently available on effectiveness of treatment of otitis media with Bactrim when infection is due to ampicillin-resistant *Haemophilus influenzae*. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.

For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.

For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.

Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: *General:* Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:

Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.

Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.

For patients with renal impairment. Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.

ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:
Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days.

PNEUMOCYSTIS CARINII PNEUMONITIS:
Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets*, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100; Prescription Paks of 20 and 28. *Tablets*, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40. *Pediatric Suspension*, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); cherry-flavored—bottles of 100 ml and 16 oz (1 pint). *Suspension*, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).

ROCHE®
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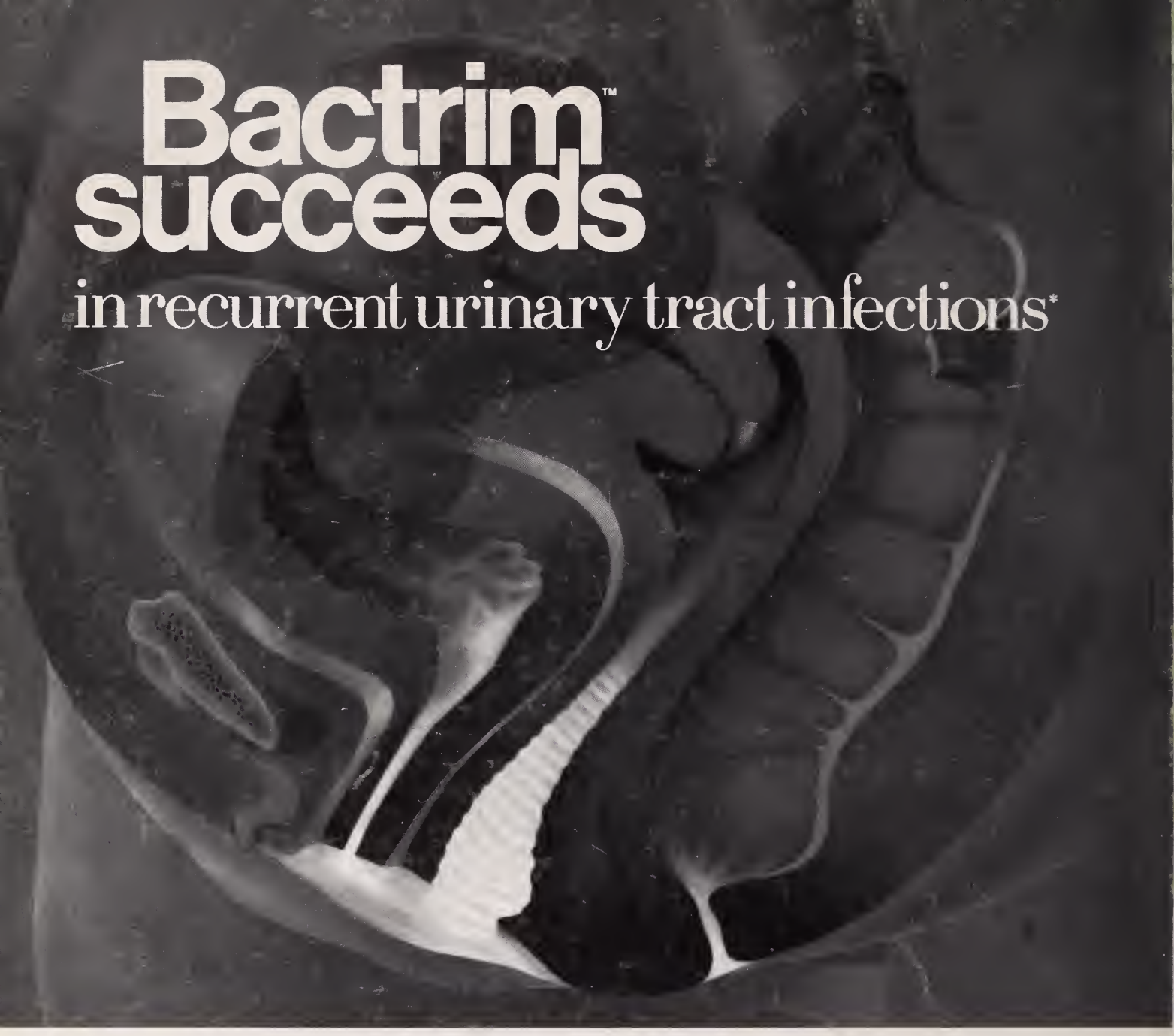
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110



Bactrim™ succeeds

in recurrent urinary tract infections*

from site to source

Bactrim continues to demonstrate high clinical effectiveness in recurrent urinary tract infections. Bactrim reaches effective levels in urine, serum, and renal tissue[1]...the trimethoprim component diffuses into vaginal secretions in bactericidal concentrations[1]... and in the fecal flora, Bactrim effectively suppresses Enterobacteriaceae[1,2] with little resulting emergence of resistant organisms.

1. Rubin RH, Swartz MN: *N Engl J Med* 303:426-432, Aug 21, 1980. 2. Data on file, Medical Department, Hoffmann-La Roche Inc.

Bactrim™ DS
160 mg trimethoprim and 800 mg sulfamethoxazole
DOUBLE STRENGTH TABLETS

maximizes results with B.I.D. convenience

ROCHE®

* due to susceptible strains of indicated organisms

Please see previous page for summary of product information.

STACKS

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WISCONSIN MEDICAL JOURNAL

MARCH 1982

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- Editorial: Community options [page 10]
- Editorial: Thanks Doctor Anderson [page 15]
- SMS advisory committee on Medicaid begins work [page 40]
- Sarcoid polyradiculoneuropathy with myelographic confirmation [page 21]
- Annual Meeting: Nominees for SMS offices; election May 14 [page 37]

Three important products from Dista

Nalfon® 200 fenoprofen calcium — 200-mg* Pulvules®

Nalfon® fenoprofen calcium — 300-mg* Pulvules, 600-mg* Tablets

Keflex® cephalexin — 250 and 500-mg Pulvules, 125 and 250-mg Oral Suspensions

*Present as 230.6 mg, 345.9 mg, and 691.8 mg of the calcium salt of fenoprofen dihydrate equivalent to 200 mg, 300 mg, and 600 mg fenoprofen respectively.

Additional information available to the profession on request.

DISTA

Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46285

100062

LIBRARY OF THE COLLEGE OF PHYSICIANS OF PHILADELPHIA APR 1982

THE PATIENT THINKS HE HAS HEART TROUBLE...

...YOU KNOW IT'S REALLY ANXIETY SYMPTOMS

His presenting symptoms: palpitations, chest pain, chronic exhaustion and occasional difficulties in breathing. Good reason for concern. A complete workup uncovers no organic dysfunction, but it *does* reveal excessively high levels of anxiety and apprehension.

For rapid relief you prescribe Valium (diazepam/Roche)

At times like this, Valium (diazepam/Roche) can be a potent therapeutic ally. It works promptly. Within just a few hours, the patient begins to feel calmer. And in a few days, anxiety relief not only becomes more pronounced but a noticeable reduction in anxiety-generated somatic symptoms also occurs.

Equally important, Valium is generally well tolerated. Side reactions more serious than drowsiness, ataxia and fatigue are rare. Patients should, of course, be cautioned against driving or drinking alcohol while on Valium therapy. Periodic reassessment of the need for antianxiety medication should also be performed.

VALIUM® (IV)
diazepam/Roche

2-mg, 5-mg, 10-mg scored tablets

BECAUSE YOU'RE CONVINCED THE PATIENT NEEDS IT

ROCHE®

Please see summary of product information on the following page.

VALIUM®(diazepam/Roche)

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.
Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.
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Created by the Territorial Legislature in 1841. . . representing over 5,000 member physicians in Wisconsin, comprising 55 county medical societies and 23 medical specialty sections. The purpose of the Society is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society include continuing medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, services for physicians, operation of a Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal.*

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President's Page

ALBERT J MOTZEL JR, MD

Industry and medicine sharing concerns

I WRITE THIS AS I return from a Conference in Washington DC, sponsored by the Machinery and Allied Products Institute, entitled "Health Care Cost Containment." While I am well aware that I have already broached this subject from a number of points of view, it is probably impossible to over-stress the significance of this meeting. As background, some 135 high-ranking executives of the major industries of this country (among them Allen-Bradley, Aluminum Company of America, The Boeing Company, Control Data Corp, Dresser Industries Inc, The Ford Motor Co, GTE Corp, and United States Steel Corp) spent a day and a half listening to and questioning Richard Schweiker, Secretary of Health and Human Services; Senator Orin Hatch, Chairman of the Senate Labor and Human Resources Committee; Doctor Nesbitt, Past President of the AMA; ranking officials of the American Hospital Association; private insurance industry; the Blue Cross Association; several private consulting firms; and three major manufacturers with recently developed, but presumably successful, cost-containment strategies, John Deere and Co, Republic Steel Corp, and Reliance Electric Company.

These executives represented diverse private industries investing some 67 billion dollars in healthcare in 1981. With this figure increasing at a current rate of about 15 percent per year and the prospect of the federal government shifting some formerly government-paid costs to them as well, they are very serious about controlling these expenses.

These executives are perceptive enough to realize that much fault lies with industry. In the past when times were good and healthcare less expensive, they negotiated away first-dollar coverage and affluent benefits. Some even believe that in the present climate it may be possible to regain some benefits such as copayment or first-dollar coverage for hospitalization or emergency room use. But make no mistake they also have serious concerns over fee abuse and especially over the abuse of utilization of hospitals and procedures, as well as the duplication of expensive equipment and facilities.

Some seem not to perceive that the product being purchased has changed dramatically over the past 30 years, and that it is not the procedure or treatment or diagnostic study of that era which has escalated out of proportion in cost. On the other hand, it is incumbent on the medical community to demonstrate that the outcome in terms of human values (if not productivity) justifies the increases in cost over and above those attributable to inflation generally.

Only a few have the vague but uncomfortable feeling that medical advances have, or may shortly make possible, more desirable treatments or procedures for more people than our society is able, or at least willing, to pay for, even when all waste and abuse has been eliminated. This possibility, however, was considered by a few with dire consequences predicted in the social structure if restrictions in availability of care was perceived to fall most heavily on the elderly or specific social groups.

In addition to the above there are some important individual observations of which I believe you should be aware:

- Some (John Deere) felt that physician involvement was crucial and had generally been productive, cooperative, and significantly contributory to the success of their cost-containment efforts.
- Some (Republic Steel) seemed hostile to physician involvement—frequently an attitude attributable to poor experience or to lack of concerted effort to achieve such input (possibly based on prior perceptions of the responsible executive). There was even an expressed threat to "hire our own physicians" and if necessary "build our own hospital" if desired results could not be achieved by other means.
- There was a recognition of the critical role of industrialists in health planning and of the role of company executives on hospital boards.
- There was recognition of the need of utilization review and review of UCR (usual, customary, and reasonable) fees and hospital billings—the

former by physicians or if this is unsuccessful, by whomever will contract for and carry out the process efficiently (*ie,* cost effectively).

I believe the above observations can be viewed with alarm, indignation, and defensiveness—I believe they can be shrugged off, ignored, and treated as though they couldn't influence our practices or our patients—or—I believe they can be taken seriously for the increasingly important change in attitude they portray. I believe we have only a little time to recognize and respond to the problems conveyed in this meeting. And what is that response to be?

Among the objectives that we set for this year at the House of Delegates meeting last March was a continuation of an objective of Doctor Lewis before—that of meeting with industrial executives in Wisconsin to air our mutual and differing concerns. This process was recommended (and begun at a national level) by the American Medical Association three years ago. During the past 12 months, some contacts have been made by officers and staff of the State Medical Society. In some areas dialog exists between county societies and a few industries. These efforts need to be expanded as quickly as possible.

It must also be recognized that in some areas anger, suspicion, and incompatible personalities almost preclude successful discussions being initiated at a local level. In these instances initial contact of industry by representatives of the State Medical Society is invaluable and should be carried out with the knowledge of the local physicians and with the goal of including representation of local societies at the earliest possible time to resolve local problems. Local problems, however, must not preclude discussion of urgent broader issues to the detriment of all.

In conclusion we must, without delay, define a program that allows state and local officers to arrange meetings with executives of industry with agendas that demonstrate our understanding of their problems and a willingness to work with them toward a mutually acceptable attempt to solve these problems to the extent that we can. The alternative is an adversarial relationship which can only serve to the mutual disadvantage of the medical profession, industry, and the public. ■

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April 14

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Human Cytogenetics
James Higgins, MD, MSU
Diagnosing Congenital Anomalies
Peter Grannum, MD, Yale
Diagnosing Inborn Errors
Henry Nadler, MD, WSU
Diagnosing the Dysmorphic Child
Murray Feingold, MD, Tufts

April 15

Screening for Metabolic Abnormalities
Michael Kaback, MD, UCLA
Serum Alpha Fetaprotein Screening
James Haddow, MD, Scarborough, MA
Teratogens: Environmental Hazards
James Hanson, MD, U. of Iowa
Michigan Genetic Disease Program
William Young, PhD, Lansing
Genetic Clinic Counseling
Diane Baker, MS, U. of Mich.
The Law and Genetics
Margery Shaw, MD, JD, Houston
Ethics in Genetic Screening
Joseph Fletcher, STD, U. of Virginia

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Editorials WAYNE J BOULANGER, MD, *Editorial Director*

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Community options

IT IS A WELL-ESTABLISHED fact that nursing home care accounts for at least 60% of the state's Medicaid budget. The percentage is growing. Wisconsin's generosity toward the care of the elderly and disabled is variously regarded as social blessing and financial curse.

The Governor's 1981-83 budget request quite appropriately proposed several actions to contain the rapidly escalating Medicaid cost. One of them deserves special mention—the Community Options program. It is an idea designed to provide the elderly and disabled with options to remain in the community, at home or in group homes, or in other family-type settings rather than face permanent institutionalization.

The Community Options Program may or may not work. Quite conceivably it may not reduce the total payout for the care of the elderly and disabled, but it certainly suggests the possibility of a better quality of life for the dollar expended. With the right kind of cooperation between groups and organizations as well as the parties directly involved, patient, families and physicians, there is a good chance that a more cost-effective and substantially more humane care program will be put in place.

Seven counties—Portage, Dane, Racine, Winnebago, Waupaca, Rusk and Pepin—will put this program on trial during the course of this year. The enthusiasm of those who have helped to shape the program to its final form is rare in government-private effort. A great deal of the credit for this development is due DHSS Secretary Percy and the staff he assigned to put this program in place. They and many others have acted with dedication and perseverance in a program whose complexities could have obscured its high ideals and hopes. It is a program worth watching and supporting. —ERT

Big man on campus

WHAT DO YOU TELL a young man who asks whether he should try out for the class play or the choir as a college student who also happens to be in premed? Should he devote the time to the a cappella choir or to obtaining straight A if his course load includes biochemistry, physics, genetics, and comparative anatomy?

Sometimes during each undergraduate student's college career he wishes to devote some time to varsity athletics, band or orchestra, dramatics, the debating team or other extra curricular activities. But in view of the intense competition for placement in medical school, the usual decision is to forgo these pleasures for a grade point average that can withstand the competition.

This has led to a type of person being qualified for medical school who oftentimes has had no experience in areas other than the narrow field of preprofessional education. In many instances his education lacks the liberal arts content that makes for a well-rounded person with a broad college education. Seldom does a varsity athlete in the major sports such as football, basketball, baseball, or hockey make the medical school team. The class presidents and leaders of student governments also fail to have a grade point average high enough for medical school acceptance.

Perhaps this indicates that a more dedicated type of student selects medicine for his career, but it also may indicate that medicine does not retain the natural political and social leaders. Apparently, the big man on campus is big only in the undergraduate years. —RAMc

Ha du snus?

THE TITLE OF THIS editorial would sound familiar to anyone raised in a Scandinavian community. It simply is a request for or offering of snuff. Recently there has been increasing concern about the use of smokeless tobacco. This, of course, refers to chewing tobacco and snuff. In the past this habit was thought to be confined largely to farmers and professional baseball players, but recently it has become more popular in the younger generation and where smoking is prohibited.

The degree of exposure depends on the amount per chew or per dip and the length of time it is held in the mouth as well as the number of times it is used in the course of the day. Although from the information available chewing and snuffing are undoubtedly less dangerous than smoking cigarettes, there has been some increase in the frequency of oral malignancies. The common precursor is leukoplakia which tends to develop at the site where the tobacco is held. It is usually reversible, but can progress to hyperkeratosis and malignancy.

Probably the most famous patient with a lesion of this type was President Cleveland in 1893. His sur-

gery was performed on a yacht at sea under strict secrecy. The final diagnosis was verrucous carcinoma of the hard palate and maxillary gingiva. It was reported that lesions of that type were found predominantly in older men and were associated with a history of chewing tobacco, the use of snuff and alcohol, as well as poor dentition.

Another famous character entitled to an oral malignancy was Bloody Mary of South Pacific lore. Anyone who served in the South Pacific or Viet Nam had the startling experience of seeing patients, especially women, with coal black teeth and drooling blood-red saliva. This resulted from the use of betel nuts and lime which apparently made the life of users slightly less miserable. Extensive oral carcinoma from this habit was all too common.

Since the use of chewing and snuffing tobacco has become more prevalent, it is important that routine physical examinations include a careful scrutiny of the mouth. —VSF

Dough, re, mi

THERE ARE FREQUENT loud lamentations about the "high cost of medical care." Recently a group of aging noisemakers called the Rolling Stones featuring Mick Jagger reported anticipated ticket sales of $40 million for their concertizing. With the sales of T-shirts and other memorabilia, the group was reported to gross $127 million. Yet we hear no complaints about the "high cost of music"—or about payments for cordons of special police for crowd and drug control at these soirees.

Similarly another popular "musical" star provided such unusual entertainment as biting off the head of a bat and maltreating a goat. Simultaneously he assaulted the eardrums of the patrons who paid high prices for the privilege of those shattering decibles.

I guess it all depends on one's scale of values—musical or medical. —VSF■

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Economics II

TO THE EDITOR: I was most interested in the discussion on economic theory which was so articulately presented by Dr Raymond McCormick in a recent issue of the *Wisconsin Medical Journal.*

In his commentary Doctor McCormick ably captured the highlights of the recently announced Blue Cross & Blue Shield United of Wisconsin "outpatient surgery program." The effort to encourage physicians and their patients to consider the use of ambulatory surgery as a substitute for more costly inpatient surgery, where medically appropriate, has been adopted by Blue Cross & Blue Shield Plans nationwide. Costs for ambulatory, or same-day surgery, can run as much as 30%-50% less than inpatient surgery, according to some experts.

One of the areas which holds promise for reducing health care costs, is to encourage subscribers to utilize existing health care resources in the most efficient manner. Where medical conditions permit, we think it makes good sense for some minor surgical procedures such as: certain hernia repairs, certain breast biopsies, tubal ligations and others, to be performed on an outpatient basis.

Doctor McCormick concludes in his editorial, that any cost savings realized by our program might be diminished by subsequent increases in hospital per diem rates which would offset any losses in inpatient revenue. Perhaps this may happen, but not necessarily. We are approaching the time when increases in hospital charges will probably be tied to other factors such as efficiency of operation, bed capacity, and other factors.

If the "outpatient surgery" program proves to be successful in reducing inpatient costs as we think it will, hospitals might give some added thought to expanding their outpatient services or developing some alternate uses of their facilities. The outpatient surgery program need not be viewed as a negative program at all from the hospital standpoint. It simply represents judicious use of medical resources.

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TO THE SOCIETY: Because of the excellent response of most of the doctors to thc Bureau of Social Security Disability Insurance's request for evidence of medical record, we have been able to complete about 70% of our decisions based on your (physicians) information and we have been able to make relatively rapid decisions for the benefit of your patients. Because of the rapidity for which we have made decisions we are in the seventh place in the nation. An equally important point, however, is that our accuracy has been within the top echelon of our Region. Many of you know that the reason for the 30% which cannot be adjudicated on the basis of reports from the treating physician is that most of these patients have not seen a doctor for many months. Therefore, we have to get consultative examinations on these people for current information. For these consults in Fiscal 1981 we spent $1,726,000. Please be advised that we need more consultative physicians on our panel of all specialties, but particularly neurology and orthopedics.

I am retiring as of December 18, 1981 and my successor will be Paul Tracy, MD whom I am sure many of you know. I hope your response to his re-

quests will be as fast and complete as they have been to mine. I would like to remind you, however, that this is a medical program. The applicants' impairments must be documented by objective findings and not just by opinion.

We also thought you would like to know that cases on which we make decisions the average is $35,000.00 per decision for the Social Security Trust Funds and your patients. Recipients and their dependents receive about a million and a half dollars each month in Wisconsin.

This work has been a great challenge to me as it has to other physicians who work here in the office. With your continued help in furnishing us with medical information of record, we can continue to do a good job and be in the top of the state agencies doing this type of work. I am sure you will be interested to know that we do approximately 1,000 cases a week and about 60% of these are denials and 40% are allowances.

Because of our need for complete documentation of these cases, it is necessary at times for us to call physicians to clear up some small points that are quite important as far as the Social Security Administration is concerned. We hope you will continue to bear with us for these calls for I know they are difficult for you to accept at times because of your busy practice, but we have found that the telephone is the fastest way to obtain this information.

Again I would like to express the thanks of our agency as well as my personal thanks for your response to our requests. I hope you will keep up the good work for my successor, Doctor Tracy.

Henry A Anderson, MD
Chief Medical Consultant
Bureau of Social Security
Disability Insurance
Division of Economic Assistance
Department of Health
& Social Services
PO Box 7623
Madison, Wisconsin 53707

EDITORIAL

Thanks, Doctor Anderson

Henry A Anderson, MD of Madison, widely known of late as the medical director for the state's total and permanent disability program under Social Security, has retired. Most know him for his 21 years of service as chairman of the State Medical Society Committee on Tuberculosis and Chest Diseases; 30 years on the board of directors of the Wisconsin Lung Association; and more than a quarter century as medical director of River Pines Sanatorium in Stevens Point. He gave many years to such diverse activities as public and student health, medical society and local "politics," and the Boy Scouts.

DOCTOR ANDERSON

For all the good things to be said for those accomplishments, he will be best remembered for his total dedication to human concerns and his passion for professional excellence, in all of which he exuded warmth, care, and kindness. A rare combination in a fine physician and a true gentleman. Thanks and best wishes. —ERT

Clinical Hypnosis

TO THE SOCIETY: We at The American Society of Clinical Hypnosis take pleasure in informing you about the activities of our Society. We are engaged in educational purposes for spreading the use of ethical hypnosis to persons holding doctoral degrees in medicine, dentistry and psychology.

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We shall be pleased to provide any services or information you might require.

Harold P Golan, DMD, President
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"WATS" LINE FOR MEMBERS

As a service for its members, the State Medical Society of Wisconsin has a **toll-free** WATS line (Wide Area Telecommunications Service) to provide member physicians with quick and easy access to SMS staff. The in-WATS line can be used to contact anyone at SMS headquarters (330 East Lakeside Street, Madison) from anywhere within the State of Wisconsin between the hours of 8:00 am and 4:30 pm weekdays. The number to dial is:

1-800-362-9080

More on the role of the nurse

TO THE EDITOR: In the November 1981 issue of the *Wisconsin Medical Journal* there was an excellent article in the section "Commentary by a Senior Physician."

Ewald H Pawsat, MD delivered an excellent and thorough analysis of the problem besetting the present nurse-physician relationship. He revealed its gradual onset and its multifaceted causes. His evaluation of the situation reflected him as a physician who was thorough and caring, the hallmark of an excellent physician

While the entire article is lucid and deserves to be read and reread by all nurses and physicians sincerely interested in healthcare, one paragraph points to much of the problem:

> "With this type of indoctrination, some members of the nursing staff tend to feel that they do not only have the 'right' but also the 'responsibility' to be the hospital patient's advocate in all health matters, including recommendation for consultation, second opinions, discussion of alternate therapies, and independent documentation of the history and physical findings, formerly strictly the domain of the physician."

Also as a senior physician, I would like to comment, but only briefly, for Doctor Pawsat's analysis has left no gaps in his thorough gathering of the symptoms and signs. My complete agreement with his findings leads me to the following conclusions:

* * *

THE ROLE OF THE NURSE, like all other members of the team, is an important one. And the first thing to remember is that the nurse is an integral part of the team. And lest we forget, so are all the members—the doctors, the nurses, the orderlies, the nurses' assistants, the laboratory technicians, and, yes, the cleaning employees. Good members of any team do not just "shoot the ball" but "pass it"—in other words, team effort.

So the first job of the nurse is to be a good member of the team. In this respect the nurse's role is no different than that of any member of the team—to use good judgment, based on his or her training and experience. Secondly, to be pliable without sacrificing any standards of morals, procedure, or knowledge. Thirdly, to be modest and tactful to assure the success of the team effort. Fourthly, to be diligent, determined, persuasive and persevering in following the patient's course of events.

For the nurse, this means following the doctor's orders implicitly, unless there is a firm belief that the orders are detrimental to the patient. It also means following the orders on time, unless precedence must be given to something more important. In either case the doctor should be notified at once as to any changes of procedure. Yet, due recognition should be given by the doctor, regarding potential legal involvement of the nurse; *ie,* in regard to improper medication given.

Finally, all members of the team should and must have one goal in mind—what is best for the patient immediately, indeed; but on a long-term basis as well. This implies all of what has been said above in a concerted effort by all team members. It also implies good leadership and an understanding of the chain of command. It implies bringing griev-

William B A J Bauer, MD—"Cited as a man of strong will and firm opinion," Doctor Bauer "is above all a man of principle." Born on Nov 13, 1911 in Brooklyn, New York, Doctor Bauer graduated from the Long Island School of Medicine in 1939. After graduation, he was a house officer at Brooklyn State Hospital for six months, and then served an 18-month internship at Minneapolis General Hospital. Licensed to practice medicine in Wisconsin in 1941, he started his medical practice in Ladysmith in 1942, retiring in 1976. Not wanting to be idle in medicine, Doctor Bauer continued to staff the emergency room at Luther Hospital, Eau Claire, three days a week. An avid fisherman, he constructed a trout hatchery and rearing pond and completed the last pond in 1957. He also was a member of the State Conservation Commission. Doctor Bauer was instrumental in the formation of the Rusk County Conservation Club and has served as its president. Athletic competition also has been a way of life for Doctor Bauer during his leisure time. He enjoys golf, bowling, and basketball. In the December 1950 issue of the *Wisconsin Medical Journal,* he was author of the article entitled "Intussusception in a Four Month Old Infant." In recalling this article Doctor Bauer noted that it had been many years since he had offered a contribution to the *Wisconsin Medical Journal*—"the infant referred to with intussusception now has a family of his own—further evidence of my age—oops seniority." In the November 1951 issue of the *Archives of Surgery,* he gave an account of the first reported case of reformed gallbladder diagnosed before surgery. Doctor Bauer's family has been a source of pride and respect for the health professions. His father was a general surgeon; two brothers, a sister, and a brother-in-law are or were members of the health professions; and his five children together with their spouses, include one nurse and four physicians.

ances up at the proper time and to the proper authorities. Silence till then is advisable. Gossip has no place in medical teamwork. Respect for each member of the team should have priority.

* * *

Like Doctor Pawsat, my family also has been a source of pride and respect for the health professions. My father, two brothers, a sister, and a brother-in-law are or were members of the medical profession (my father and one brother have died). My family of five children, together with their spouses, includes one nurse and four physicians.

In sincere hopes that with tact and expertise, the nursing and medical professions can assimilate their skills with symbiotic results for the patient...

Another Senior Physician
William B A J Bauer, MD
Ladysmith, Wisconsin■

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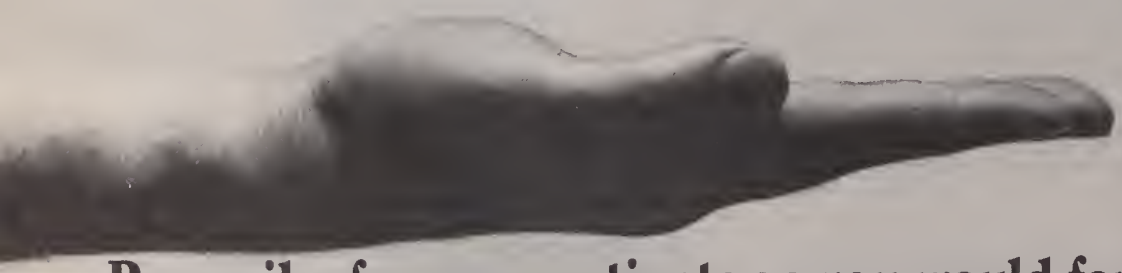

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Please see PROCARDIA® *prescribing information on next page.*

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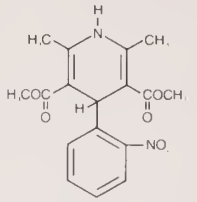
nifedipine

For Oral Use

DESCRIPTION: PROCARDIA (nifedipine) is an antianginal drug belonging to a new class of pharmacological agents, the calcium channel blockers. Nifedipine is 3,5-pyridinedicarboxylic acid, 1,4-dihydro-2,6-dimethyl-4-(2-nitrophenyl)-, dimethyl ester, $C_{17}H_{18}N_2O_6$, and has the structural formula:



Nifedipine is a yellow crystalline substance, practically insoluble in water but soluble in ethanol. It has a molecular weight of 346.3. PROCARDIA CAPSULES are formulated as soft gelatin capsules for oral administration each containing 10 mg nifedipine.

CLINICAL PHARMACOLOGY: PROCARDIA (nifedipine) is a calcium ion influx inhibitor (slow channel blocker or calcium ion antagonist) and inhibits the transmembrane influx of calcium ions into cardiac muscle and smooth muscle. The contractile processes of cardiac muscle and vascular smooth muscle are dependent upon the movement of extracellular calcium ions into these cells through specific ion channels. PROCARDIA selectively inhibits calcium ion influx across the cell membrane of cardiac muscle and vascular smooth muscle without changing serum calcium concentrations.

Mechanism of Action: The precise means by which this inhibition relieves angina has not been fully determined, but includes at least the following two mechanisms:

1) Relaxation and prevention of coronary artery spasm: PROCARDIA dilates the main coronary arteries and coronary arterioles, both in normal and ischemic regions, and is a potent inhibitor of coronary artery spasm, whether spontaneous or ergonovine-induced. This property increases myocardial oxygen delivery in patients with coronary artery spasm, and is responsible for the effectiveness of PROCARDIA in vasospastic (Prinzmetal's or variant) angina. Whether this effect plays any role in classical angina is not clear, but studies of exercise tolerance have not shown an increase in the maximum exercise rate-pressure product, a widely accepted measure of oxygen utilization. This suggests that, in general, relief of spasm or dilation of coronary arteries is not an important factor in classical angina.

2) Reduction of oxygen utilization: PROCARDIA regularly reduces arterial pressure at rest and at a given level of exercise by dilating peripheral arterioles and reducing the total peripheral resistance (afterload) against which the heart works. This unloading of the heart reduces myocardial energy consumption and oxygen requirements and probably accounts for the effectiveness of PROCARDIA in chronic stable angina.

Pharmacokinetics and Metabolism: PROCARDIA is rapidly and fully absorbed after oral administration. The drug is detectable in serum 10 minutes after oral administration, and peak blood levels occur in approximately 30 minutes. It is highly bound by serum proteins. PROCARDIA is extensively converted to inactive metabolites and approximately 80% of PROCARDIA and metabolites are eliminated via the kidneys. The half-life of nifedipine in plasma is approximately two hours. There is no information on the effects of renal or hepatic impairment on excretion or metabolism of PROCARDIA.

Hemodynamics: Like other slow channel blockers, PROCARDIA exerts a negative inotropic effect on isolated myocardial tissue. This is rarely, if ever, seen in intact animals or man, probably because of reflex responses to its vasodilating effects. In man, PROCARDIA causes decreased peripheral vascular resistance and a fall in systolic and diastolic pressure, usually modest (5–10 mm Hg systolic), but sometimes larger. There is usually a small increase in heart rate, a reflex response to vasodilation. Measurements of cardiac function in patients with normal ventricular function have generally found a small increase in cardiac index without major effects on ejection fraction, left ventricular end diastolic pressure (LVEDP) or volume (LVEDV). In patients with impaired ventricular function, most acute studies have shown some increase in ejection fraction and reduction in left ventricular filling pressure.

Electrophysiologic Effects: Although, like other members of its class, PROCARDIA decreases sinoatrial node function and atrioventricular conduction in isolated myocardial preparations, such effects have not been seen in studies in intact animals or in man. In formal electrophysiologic studies, predominantly in patients with normal conduction systems, PROCARDIA has had no tendency to prolong atrioventricular conduction, prolong sinus node recovery time, or slow sinus rate.

INDICATIONS AND USAGE: I. Vasospastic Angina: PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

II. Chronic Stable Angina (Classical Effort-Associated Angina): PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta-blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Increased Angina/Beta Blocker Withdrawal: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients usually receiving a beta blocker have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event, as the unloading effect of PROCARDIA would be expected to be of less benefit to these patients, owing to their fixed impedance to flow across the aortic valve.

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. See Warnings.

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug interactions: Beta-adrenergic blocking agents: See Indications and Warnings. Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Carcinogenesis, mutagenesis, impairment of fertility: Nifedipine was administered orally to rats for two years and was not shown to be carcinogenic. When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose. *In vivo* mutagenicity studies were negative.

Pregnancy: Pregnancy category C. Nifedipine has been shown to be teratogenic in rats when given in doses 30 times the maximum recommended human dose. Nifedipine was embryotoxic (increased fetal resorptions, decreased fetal weight, increased stunted forms, increased fetal deaths, decreased neonatal survival) in rats, mice and rabbits at doses of from 3 to 10 times the maximum recommended human dose. In pregnant monkeys, doses 2/3 and twice the maximum recommended human dose resulted in small placentas and underdeveloped chorionic villi. In rats, doses three times the maximum human dose and higher caused prolongation of pregnancy. There are no adequate and well-controlled studies in pregnant women. PROCARDIA should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

ADVERSE REACTIONS: In multiple-dose U.S. and foreign-controlled studies in which adverse reactions were reported spontaneously, adverse effects were frequent but generally not serious and rarely required discontinuation of therapy or dosage adjustment. Most were expected consequences of the vasodilator effects of PROCARDIA.

Adverse Effect	PROCARDIA (%) (N = 226)	Placebo (%) (N = 235)
Dizziness, light-headedness, giddiness	27	15
Flushing, heat sensation	25	8
Headache	23	20
Weakness	12	10
Nausea, heartburn	11	8
Muscle cramps, tremor	8	3
Peripheral edema	7	1
Nervousness, mood changes	7	4
Palpitation	7	5
Dyspnea, cough, wheezing	6	3
Nasal congestion, sore throat	6	8

There is also a large uncontrolled experience in over 2100 patients in the United States. Most of the patients had vasospastic or resistant angina pectoris, and about half had concomitant treatment with beta-adrenergic blocking agents. The most common adverse events were the same ones seen in the controlled trials, with dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

Several of these side effects appear to be dose related. Peripheral edema occurred in about one in 25 patients at doses less than 60 mg per day and in about one patient in eight at 120 mg per day or more. Transient hypotension, generally of mild to moderate severity and seldom requiring discontinuation of therapy, occurred in one of 50 patients at less than 60 mg per day and in one of 20 patients at 120 mg per day or more.

In addition, 2% or fewer of patients reported the following: **Respiratory:** Nasal and chest congestion, shortness of breath. **Gastrointestinal:** Diarrhea, constipation, cramps, flatulence. **Musculoskeletal:** Inflammation, joint stiffness, muscle cramps. **CNS:** Shakiness, nervousness, jitteriness, sleep disturbances, blurred vision, difficulties in balance. **Other:** Dermatitis, pruritus, urticaria, fever, sweating, chills, sexual difficulties.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

In a subgroup of over 1000 patients receiving PROCARDIA with concomitant beta blocker therapy, the pattern and incidence of adverse experiences was not different from that of the entire group of PROCARDIA treated patients (see **Precautions**).

In a subgroup of patients with a diagnosis of congestive heart failure as well as angina, dizziness or light-headedness, peripheral edema, headache or flushing each occurred in one in eight patients. Hypotension occurred in about one in 20 patients. Syncope occurred in approximately one patient in 250. Myocardial infarction or symptoms of congestive heart failure each occurred in about one patient in 15. Atrial or ventricular dysrhythmias each occurred in about one patient in 150.

Laboratory tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have already been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

OVERDOSAGE: Although there is no well documented experience with PROCARDIA overdosage, available data suggest that gross overdosage could result in excessive peripheral vasodilation with subsequent marked and probably prolonged systemic hypotension. Clinically significant hypotension due to PROCARDIA overdosage calls for active cardiovascular support including monitoring of cardiac and respiratory function, elevation of extremities, and attention to circulating fluid volume and urine output. A vasoconstrictor (such as norepinephrine) may be helpful in restoring vascular tone and blood pressure, provided that there is no contraindication to its use. Clearance of PROCARDIA would be expected to be prolonged in patients with impaired liver function. Since PROCARDIA is highly protein-bound, dialysis is not likely to be of benefit.

DOSAGE AND ADMINISTRATION: The dosage of PROCARDIA needed to suppress angina and that can be tolerated by the patient must be established by titration. Excessive doses can result in hypotension.

The starting dose is one 10 mg capsule, swallowed whole, 3 times/day. The usual effective dose range is 10–20 mg three times daily. Some patients, especially those with evidence of coronary artery spasm, respond only to higher doses, more frequent administration, or both. In such patients, doses of 20–30 mg three or four times daily may be effective. Doses above 120 mg daily are rarely necessary. More than 180 mg per day is not recommended.

In most cases, PROCARDIA titration should proceed over a 7–14 day period so that the physician can assess the response to each dose level and monitor the blood pressure before proceeding to higher doses.

If symptoms so warrant, titration may proceed more rapidly provided that the patient is assessed frequently. Based on the patient's physical activity level, attack frequency, and sublingual nitroglycerin consumption, the dose of PROCARDIA may be increased from 10 mg t.i.d. to 20 mg t.i.d. and then to 30 mg t.i.d. over a three-day period.

In hospitalized patients under close observation, the dose may be increased in 10 mg increments over four to six-hour periods as required to control pain and arrhythmias due to ischemia. A single dose should rarely exceed 30 mg.

No "rebound effect" has been observed upon discontinuation of PROCARDIA. However, if discontinuation of PROCARDIA is necessary, sound clinical practice suggests that the dosage should be decreased gradually with close physician supervision.

Co-Administration with Other Antianginal Drugs: Sublingual nitroglycerin may be taken as required for the control of acute manifestations of angina, particularly during PROCARDIA titration. See **Precautions, Drug Interactions** for information on co-administration of PROCARDIA with beta blockers or long-acting nitrates.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA Capsule contains 10 mg of nifedipine. PROCARDIA Capsules are supplied in amber glass bottles of 100 capsules (NDC 0069-2600-66).

The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

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Issued January 1982

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PFIZER INC NEW YORK N.Y. 10017

Sarcoid polyradiculoneuropathy with myelographic confirmation. . .

Thomas R Marra, MD, Milwaukee, Wisconsin

ABSTRACT. *Metrizamide lumbar myelography was performed on a 36-year-old woman who presented with amenorrhea, galactorrhea, progressive lower extremity weakness and electromyographic evidence of polyradiculoneuropathy. Multiple discrete contour irregularities and fusiform thickening of the nerve roots of the cauda equina were seen. Subsequent biopsy of a sphenoid sinus mucocele revealed noncaseating granulomatous inflammation consistent with the diagnosis of sarcoidosis. Metrizamide myelography appears to offer advantages over conventional oil based myelography for the delineation of subtle nerve root abnormalities and may have diagnostic utility in the evaluation of other forms of neuropathy, particularly of hypertrophic or infiltrative origin.*

SARCOID NERVOUS SYSTEM involvement is relatively uncommon. Delaney reviewed the literature from 1941 to 1974 and found neurologic manifestations in 5% of 5092 reported cases of sarcoidosis.[1] Rarely, nervous system involvement alone may occur, and in such cases the diagnosis can be exceedingly difficult. Although multiple areas of the nervous system may be involved, there appears to be a predilection for the basilar leptomeninges, cranial nerves, pituitary-hypothalamic axis, peripheral nerves and muscle.[1-5] Involvement of spinal cord [6,7] and cauda equina [2,8,9] has only rarely been reported in the literature and there are thus relatively few reports of myelographic abnormalities.

It is the purpose of this communication to present a case of primary neurosarcoidosis manifested by amenorrhea-galactorrhea and intracranial hypertension with both clinical and electrophysiologic evidence of polyradiculoneuropathy. Metrizamide lumbar myelography demonstrated subtle contour irregularities of the cauda equina suggesting direct sarcoid infiltration of multiple nerve roots.

CASE REPORT. A 36-year-old, black woman was admitted to the hospital in October 1979 with symptoms of headache, amenorrhea, galactorrhea, and lower extremity weakness. Six months before admission a serum pregnancy test was negative and the serum prolactin level was moderately elevated (34 ng/ml). Three months before admission polytomography of the sella turcica was normal. Two months before admission she began to notice difficulty rising from a chair, moderate fatigue, low back aching discomfort, and tingling paresthesias in her feet.

Over the previous eight months she had experienced a 35 kg weight gain, polyuria, polydipsia, and nocturia. She had a history of two normal pregnancies with uneventful vaginal deliveries 19 and 20 years before admission. A tubal ligation was performed four years before admission at which time oral contraceptive medication was discontinued. Her menstrual periods were monthly and regular until her menses ceased. She had noted occasional blurred vision but denied diplopia or visual field changes. She had a known history of sickle cell trait. Her only medication had been acetaminophen for headaches.

The general medical examination disclosed an obese (107 kg) black female with normal vital signs and no abnormalities except for galactorrhea. The neurologic examination showed early bilateral papilledema. Detailed muscle strength testing disclosed symmetrical proximal lower extremity weakness of Grade 4 (5 point scale) involving hip abduction, adduction, flexion, and extension. Deep tendon reflexes were trace in both upper extremities. The knee and ankle jerk reflexes were absent bilaterally. Vibratory sense was impaired in both feet. Other sensory modalities were intact. Babinski signs were absent. The gait was on a slightly widened base but without truncal or extremity ataxia on formal cerebellar testing.

Laboratory. Laboratory data included a normal routine blood cell count, chemistry panel, CPK, aldolase, B12, folate, ANA, and 24-hour urine collection for heavy metals and porphyrins. The chest x-ray film showed rare scattered calcified granulomata. Intermediate strength PPD was nonreactive and mumps reactivity was normal. A repeat prolactin level was again elevated (46 ng/ml).

Special studies. Nerve conduction velocity studies in the left upper and lower extremities were normal for both motor and sensory parameters: the com-

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FIGURE 1—*Metrizamide lumbar myelography demonstrating multiple contour irregularities and fusiform thickening of the nerve roots of the cauda equina.*

mon peroneal nerve distal motor latency (DML) was 4.1 msec and the motor nerve conduction velocity (MNCV) was 41.4 meters/second. The median nerve DML was 3.4 msec and the MNCV 50.0 meters/second. The sural nerve distal sensory latency was 3.8 msec. The resting EMG needle examination was abnormal showing signs consistent with acute denervation reaction manifested by trains of positive sharp wave potentials and bizarre high frequency discharges diffusely involving both upper and lower extremities. Similar changes were recorded from lumbar and thoracic paraspinal regions. There was slightly decreased voluntary recruitment of motor units of normal amplitude, duration, and appearance. Lumbo-sacral metrizamide myelography disclosed multiple discrete contour irregularities of the nerve roots of the cauda equina, manifesting as either fusiform thickening or excessive nodularity (Fig 1).

Spinal fluid analysis was performed on four occasions. Clear, colorless fluid was obtained in each case (Table 1). Protein ranged from 194 to 287 mg%; sugar 20-30 mg%; blood cell count, 3-49 WBCs (90% lymphocytes). Cytologic examination was negative for malignant cells on four occasions, positive for single histiocyte on one occasion. All specimens were negative for bacterial cultures, AFB, and cryptococcus. Spinal fluid protein electrophoresis showed a maximum gamma globulin of 26.4%. Counter current immunoelectrophoresis for common bacterial pathogens was negative. Muscle biopsy from the right vastus lateralis showed signs of both acute and chronic denervating atrophy but no specific pathognomonic lesion.

The EEG was abnormal showing a mild diffuse disturbance of cerebral function. High resolution head computerized tomographic (CT) scanning with attention to the juxtasellar region showed slight ventriculomegaly and a normal sella turcica. Incidental erosion of the floor of the sphenoid sinus was noted and subsequently confirmed with polytomograms. Biopsy of the sphenoid sinus revealed a mucocele, beneath the epithelial surface of which were noted multinucleated giant histiocytes surrounding areas of noncaseating granulomatous inflammation consistent with the diagnosis of sarcoidosis (Fig 2).

Course. Following the sphenoid biopsy, treatment with dexamethasone, 2 mg, three times daily was begun. Headaches ceased within 24 hours and the patient became normally ambulatory within three days with only mild residual proximal lower extremity weakness. Therapy with alternate-day prednisone, 20 mg, was continued and the patient remained essentially without symptoms for the next six months. Attempts to discontinue steroids resulted in recurrence of generalized headache and mild lower extremity weakness. The resting EMG again disclosed active denervation in both lower extremities, thoracic and lumbar paraspinal regions. Spinal fluid analysis revealed normal appearing fluid with a protein of 194 mg% and sugar of 30 mg%. Reinstitution of steroid therapy again produced a remission of symptoms, and she has remained relatively symptom-free to the present time (May 1981).

DISCUSSION. We believe the present case demonstrates disseminated neurosarcoidosis manifested by pituitary-hypothalamic dysfunction, polyradiculoneuropathy, and intracranial hypertension. Associated findings included markedly elevated spinal fluid protein and hypoglycorrhachia. The spinal fluid and myelographic abnormalities suggested diffuse leptomeningeal and nerve root infiltration as the etiology for the patient's polyradiculoneuropathy. In the absence of overt peripheral manifestations of sarcoidosis, this case proved an exceedingly difficult diagnostic puzzle, eventually requiring biopsy of a sphenoid sinus mucocele to demonstrate noncaseating granulomatous inflammation.

Commenting on the diagnosis of nervous system sarcoid, Delaney[1] noted that an elevated CSF protein, lymphocytosis, and hypoglycorrhachia in the presence of negative cytology and cultures for

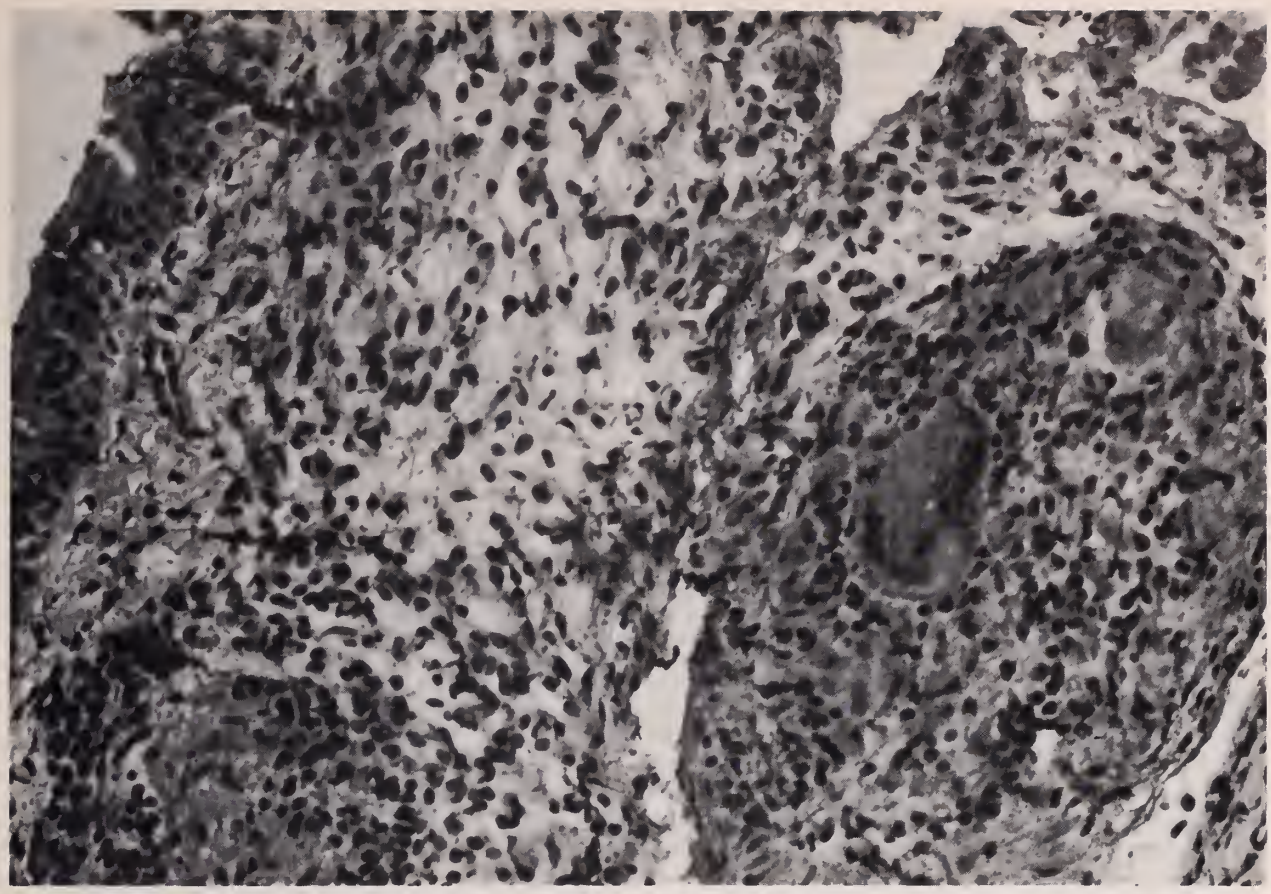

FIGURE 2—*Photomicrograph of sphenoid sinus mucocele. Beneath the epithelial surface there are multinucleated giant cells and areas of noncaseating granulomatous inflammation compatible with the diagnosis of sarcoidosis. Original magnification x16.*

TABLE 1—*Lumbar puncture results*

Date	OP	Color	Cytology	WBC*	Glucose mg % (CSF/Blood)	Protein mg%	%Gamma globulin (NL < 12.5%)	VDRL	AFB	Cryptococcus
10/10	—	Clear colorless	Single histiocyte	20	21/88	287	23.6	Negative	Negative	Negative
10/15	150	Clear colorless	Negative	43	20	270	26.4	Negative	Negative	Negative
10/31	460	Clear colorless	Negative	3	23	228	—	—	Negative	Negative
6/11	—	Clear colorless	Negative	49	30/120	194	—	Negative	—	—

*All differential counts contained 90% lymphocytes

bacteria, acid fast bacilli, and fungi are supportive of the diagnosis of leptomeningeal sarcoidosis. In the present case spinal fluid protein was high enough that it may well have significantly contributed to the observed intracranial hypertension by interfering with spinal fluid resorption across the arachnoid villi. Such an explanation has been invoked as a cause for the occasionally encountered case of Guillain-Barré syndrome with papilledema.[10]

The most striking feature of this case was the demonstration of nerve root contour irregularities with metrizamide (water soluble) myelography, suggesting granulomatous infiltration of nerve roots. Peripheral neuropathy has been estimated to occur in 15% of cases of neurosarcoidosis,[1] both mononeuritis[11] and polyneuropathy[5] having been described. A Guillain-Barré-like syndrome also has been reported.[9] From the standpoint of pathology,

Mazza[12] described fusiform swelling of the median, radial, and ulnar nerves at autopsy. Oh[5] recently reported the results of sural nerve biopsy in a case of sarcoid polyneuropathy and described direct granulomatous infiltration of epineurial and perineurial spaces, periangiitis and axonal degeneration. He concluded that direct infiltration of peripheral nerves was the basis of sarcoid polyneuropathy. The myelographic findings in this case would appear to correlate very well with this explanation. In retrospect the finding of a single histiocyte of normal morphology on cytologic CSF examination might have suggested a diagnosis. These cells play a prominent role in various chronic granulomatous diseases and their presence in the CSF may have reflected a process of cellular sloughing from the sarcoid nerve root vegetations.

There are relatively few reports of myelographic abnormalities visualized in other forms of peripheral neuropathy. Charcot-Marie-Tooth disease[15] and hypertrophic interstitial neuritis[16,17] may produce myelographic evidence of diffuse enlargement of nerve roots. Glass[18] described abnormal myelographic results in 7 of 18 cases of leptomeningeal carcinomatosis, occasionally encountering multiple nodular defects on nerve roots. The myelographic findings in neurofibromatosis also are well known.[19]

Although cases of lumbosacral adhesive arachnoiditis due to sarcoidosis have previously been noted,[2,8,9] we believe this to be the first reported case demonstrating myelographic evidence of infiltrative polyradiculoneuropathy.

Metrizamide is a nonionic, water soluble compound with low osmolality that appears to offer advantages over conventional oil based myelography for the demonstration of subtle nerve root anatomy.[13,14] It is probable that the nerve root abnormalities described would not have appeared with conventional oil based myelography and metrizamide may yet prove to have diagnostic utility in other forms of neuropathy, particularly those of hypertrophic or infiltrative etiology.

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ABSTRACT

Regional results of acute appendicitis care

DON E DETMER, MD; LINDA E NEVERS: E D SIKES, JR, MA, MSIE; Departments of Preventive Medicine and Surgery, University of Wisconsin-Madison and Wisconsin Professional Review Organization, Inc, Madison, Wis: *JAMA* 246:1318-1320, 1981

The Wisconsin Professional Review Organization, Inc (WisPRO) selected a sample of 2,375 cases of acute appendicitis from the 3,170 cases reported by 74% of all Wisconsin hospitals outside the greater Milwaukee area in 1978. The sample was statistically representative and reflected contemporary primary appendicitis care in the predominantly nonmetropolitan area. Eighty percent of primary appendectomies occurred in patients 5 to 30 years of age; 55.5% were in males. The average hospital stay was 5.4 days, except for ruptured/perforated cases in which it was 10.2 days. The wound complication rate was 5.3% and mortality 0.17%. Rupture or perforation occurred in 13.4%; 62% of these problems developed in males. Normal appendices were reported in 14.1% of all cases, with over 60% in women. Among patients of all ages, 20% of females and 10% of males had normal appendices. The rate of normal appendices removed was highest in small hospitals. The data suggested that regional care for acute appendictis in Wisconsin was generally safe and efficient, although there were wide variations in perforation rates and false positive results reported by individual hospitals. Further improvements in care could be achieved through efforts to educate the public, especially young people; to operate less frequently on patients with marginal indications for surgery; to consider laparoscopy in young women before operating; to give special attention to patients over 80 years of age; to consider increasing diagnostic accuracy by using a human- and computer-aided diagnosis of abdominal pain; and to periodically review multi-hospital performance data.

(Prepared by Dorothy J Buchanan-Davidson, PhD) ■

Long-term, ambulatory, continuous intravenous infusion of 5-fluorouracil for the treatment of metastatic adenocarcinoma in the liver. . .

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ABSTRACT. *Three patients with extensive liver metastases from gastrointestinal cancer underwent long-term, continuous, ambulatory, intravenous infusion of 5-fluorouracil, an antitumor agent. Two different pumps were used in these treatments. In two of the patients an improvement was seen in pretreatment abnormal liver function studies. Each received a large total dose of the drug. Toxicity was less severe than expected.*

A CONFIRMATION of tumor tissue in the liver, metastatic from a distant primary lesion in the gastrointestinal tract, is perceived by many physicians as a time in the clinical course of disease when there is minimal useful therapy to offer a patient. The frequency and hopelessness of this problem mandates that every imaginative effort be made to devise techniques which may improve the survival interval of such patients.

The purpose of this report is to describe adaptations we have made in traditional approaches to antitumor chemotherapy for gastrointestinal cancer liver metastases. By providing this preliminary information, we seek to encourage others to evaluate these methods and determine if satisfying efficacy can be demonstrated in the form of increased frequency of tumor tissue response and/or prolongation of patient survival.

The basis of our technique is to give a continuous flow of 5-fluorouracil into the vascular system using an ambulatory infusion pump for periods of time that are limited only by the development of toxicity. To do so, a constant *intravenous* access was established. Patients maintained full ambulation and pursued generally unrestricted daily activities. They made outpatient visits to monitor progress and toxicity.

TECHNIQUE. ***Vascular access.*** Because silicone rubber often is tolerated for substantial time in intravascular spaces, we elected to use a long (20″) catheter made of this material.* It was inserted in a vein at the antecubital fossa and propelled centrally by rotation of the drum introducer device. The tip of the catheter was located in the superior vena cava when the insertion procedure was concluded.

The flexibility of silicone permitted a full range of arm motion. Every day the antecubital region was cleansed by the patient, a small amount of ointment containing an antiseptic was placed where the skin was penetrated, and a gauze bandage applied. No significant effort was made to achieve an occlusive dressing. Patients usually used a final outer wrap of a loose elastic bandage which gave them a desirable sense of security and protection.

Ambulatory infusion. Two different continuous infusion pumps were employed. One device is an occlusive roller pump with a non air-dependent disposable plastic bag serving as a drug reservoir having a 55 ml maximum capacity.

The energy source to run the pump is a rechargeable nickel cadmium battery (Fig 1). The size (3″ x 1-1½″ x 5″) and weight (about 15 ounces) allow the patient to carry the pump in a trouser or jacket pocket. This apparatus is user controlled at one of four rates of flow (12, 24, 36, and 48 ml/day) which, along with the ability to alter drug concentration in the reservoir, gives a substantial range of daily drug dosages.

The operating principle of the second pump is the Hagen-Poiseuille Law** which states that flow through a tube is a function of pressure difference, radius of the tube lumen, length of the tube, and viscosity of the fluid. In this pump an elastomeric balloon provides both a force to move the fluid and

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*INTRASIL-VICRA, Travenol Laboratories, Deerfield, Ill.

**$F = \frac{\triangle P \times \pi r^4}{8 \times \text{viscosity} \times \text{length}}$

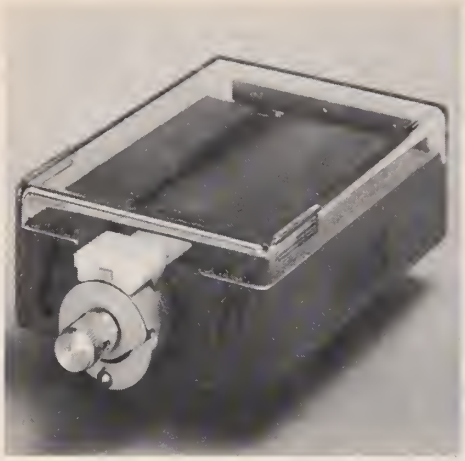

FIGURE 1—*MVP ambulatory infusion pump with nickel cadmium battery.*

FIGURE 2—*Twenty-four hour infusor. Drug reservoir is balloon in center of pump.*

a reservoir for the drug (Fig 2). The elastomer exerts a constant pressure on the fluid independent of volume. No outside energy source is necessary. The entire apparatus is disposable, and the useful filling volume of over 48 ml is intended to be a 24-hour supply of medication delivered at 2 ml/hour. Total drug dose is modified by changing its concentration in the fluid; rate changes are not possible. This pump weighs less than three ounces when filled and has the configuration of a cylinder one inch in diameter and five inches in length. Typically, it is carried in a shirt pocket or pinned to clothing where it is hidden from view, a feature appreciated by some patients.

CASE REPORTS. ***Case 1.*** A 67-year-old white male entered the hospital with findings of anemia and a palpable mass in the lower right abdomen. During a laparotomy, a large carcinoma of the cecum was excised, and biopsy confirmed the existence of extensive metastatic nodules throughout the liver. Continuous intrahepatic artery 5-fluorouracil (500 mg/day) chemotherapy was initiated several days following surgery through a catheter inserted in the brachial artery. The duration of this treatment phase was 34 days when a patient error occurred in handling the catheter, resulting in its complete occlusion by a blood clot. At the patient's request treatment was suspended temporarily. It was begun again about 60 days later, this time using a long silicone intravenous catheter placed at the antecubital fossa and ending in the superior vena cava. A dose of 500 mg/day of 5-fluorouracil was sustained for 63 days at which time diarrhea and moderate stomatitis developed, signaling toxicity. No depression of the peripheral white blood cell count or platelets was noted in subsequent days; the signs of toxicity remitted within 48 hours after treatment was stopped. Some of the hematology studies for this patient are shown in Figure 3. At this time the patient is doing well, 18 months following first treatment. Another course of chemotherapy was initiated recently when it was noted that liver function chemistries worsened. Total drug dose to date has been 100 gm, approximately 1.5 gm per kg body weight.

Case 2. The major admission complaint of this patient was intermittent rectal bleeding of nearly two years' duration. A cancer of the sigmoid colon was resected shortly after this 45-year-old white male entered the hospital. Substantial liver metastases were noted at surgery. Following a post-surgery recovery of about three weeks, a long silicone catheter was placed from the antecubital fossa to the superior vena cava, and continuous intravenous 5-fluorouracil infusion was begun (500 mg/day). At this writing 118 gm of 5-FU have been infused (approximately 1.6 gm per kg body weight); more than 236 days have passed. Therapy is still in progress. Liver function studies were not abnormal when treatment was begun in spite of massive hepatic metastasis. There has been no change in this status and no change in peripheral white blood cell count or platelet count. Thirteen months have passed since surgery.

Case 3. Deepening jaundice during a four-week period was manifest by this 48-year-old white male who underwent a laparotomy at which a pancreatic carcinoma and liver metastases were found. During surgery a biliary and gastrointestinal bypass were done to obtain immediate relief of a common bile duct obstruction. Continuous intravenous infusion of 5-fluorouracil was begun (500 mg/day) shortly after surgery and lasted 20 days at which time signs of toxicity appeared (stomatitis, diarrhea). There was no peripheral white blood cell or platelet count depression. The catheter was maintained patent with a heparin infusion; ten days later treatment was begun again at 300 mg/day of 5-FU and is continuing at this time (105 days to date; total dose 42 gm or 0.67 gm per kg body weight). There has been significant clinical improvement. Liver function studies have changed toward normal (Fig 4).

DISCUSSION. Excepting a major resection which can be accomplished with effectiveness only rarely when dealing with cancer metastatic to the liver, there is little to be offered patients having this problem. Treatment with one of the standard regimens of 5-fluorouracil is associated with a response in 10 to 20 percent of patients.[1,2] This benefit often is of short duration.

Hepatic intraarterial chemotherapy was reported first by Sullivan and Watkins[3] who wrote of a 60 percent success rate. Other investigators have described equal or similar results. Grage and colleagues[4] have made a comparison between continuous intraarterial and intermittent intravenous routes of administration. They found essentially no difference in efficacy. However, the duration of the continuous infusion protocol was 14 days, shorter if toxicity became evident. A true test of hepatic artery infusion chemotherapy may not have been accomplished, and its comparison with intravenous treatment in such circumstances may be inappropriate.

There are three important features demonstrated by the patients we are reporting: (1) the long duration infusion of 5-FU, (2) the ambulatory mode which permits normal daily activities, and (3) the continuous intravenous route of delivery. We believe it is possible that the substantial amount of chemotherapy our patients have received compared to what would be expected in a standard protocol may have significant impact on the rates of tumor response. Our limited experience exemplified by these three cases mandates a very cautious interpretation of the results. However, the ease with which the treatment program has been implemented and maintained seems worthy of note. Possibly agents other than 5-FU may have improved therapeutic ratios when used in this way. Such observations have been reported for doxorubicin hydrochloride (Adriamycin™).[5,6] Since the toxicity of 5-fluorouracil can be modified by changes in rate of administration,[7,8] the extended duration of infusion we have used may mitigate the intensity of toxic reactions and delay their onset considerably.

It is our opinion that intravenous infusion is easier to initiate and sustain than an intraarterial access. The central terminating vascular catheter has eliminated any concern for extravascular tissue infiltration of the drug.

5-Fluorouracil is an antitumor agent of the antimetabolite class. A single intravenous injection leaves no trace of drug in the blood stream after three hours. Bruce and Meeker[9] have shown that proliferating cells in any part of their cycle are equally sensitive to 5-fluorouracil. Cells which are in a normal or transitional phase, such as normal hematopoietic cells, have less sensitivity. As tumor size increases, the number of cells participating actively in synthesis or division becomes smaller so that ultimately the total cell population tends to reach a plateau.[10] Seemingly indolent cells will resume DNA synthesis when they become part of a reduced cell census, a circumstance which may be similar to the diminution of total tumor burden following palliative resective surgery. It is at this time 5-fluorouracil conceivably has its best effect. Continuous infusion provides a constant blood level of antitumor agent compared to intermittent dosage, daily or weekly. Its uninterrupted presence may make 5-FU more effective against cells as they become proliferative.

These patients have had complete freedom to follow a life style of their choosing. Patient 3 has returned to work. Patient 1, who is retired, and patient 2 have the same vigor as persons unencumbered by serious malignancy. Pumps seem to have

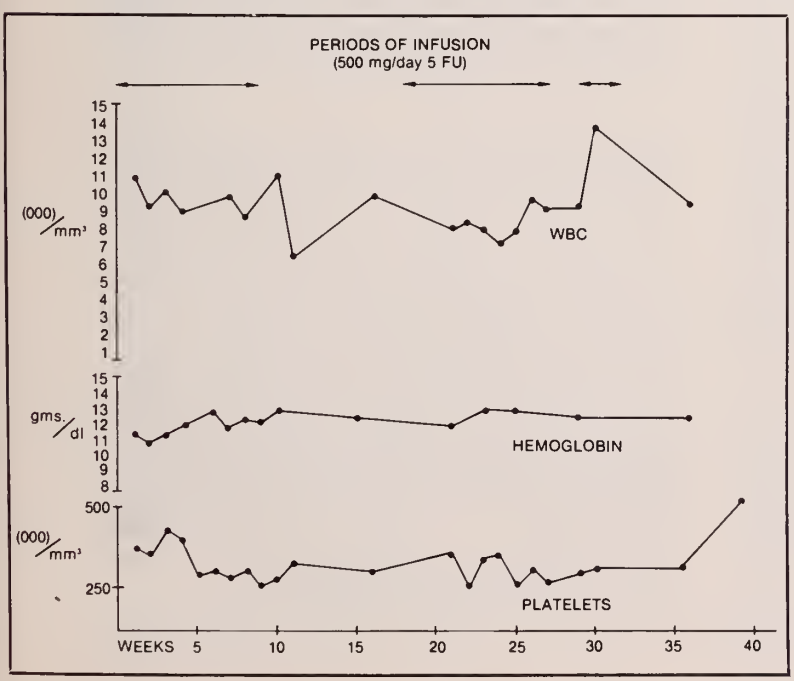

FIGURE 3—*Hematology data for Patient 1.*

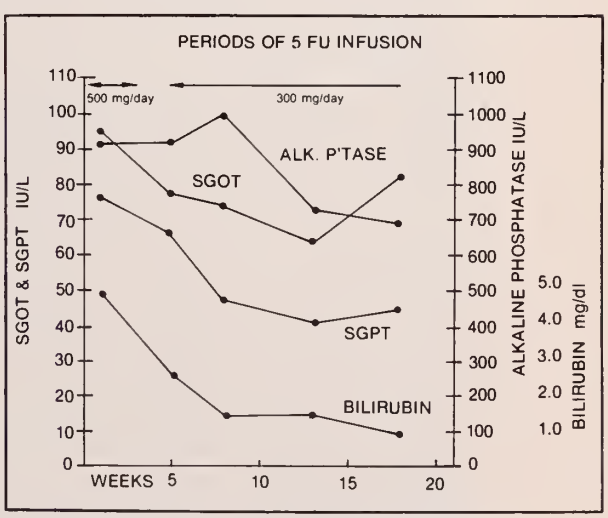

FIGURE 4—*Liver function data for Patient 3.*

created no burden or annoyance. We have been impressed with the rapidity of patients' adaptation to this therapeutic modality and the sense of well being they exude. To date the pumps in this program have functioned adequately and reliably. The prolonged periods of use have provided a good test of these infusion systems.

This study was not a controlled evaluation of a therapeutic modality. However, we have noted the experience of Bengmark and Hafstrom[11] in which 18 of 32 patients with hepatic metastasis had an elevated serum alkaline phosphatase. Only one of the 18 patients (6%) remained alive after seven months. Both patients 1 and 3 in this report had hyperenzymemia (alkaline phosphatase, SGOT, SGPT) when treatment was begun. Jaffe and colleagues reported that persons with marked elevation of alkaline phosphatase had a very poor prognosis; more than one-half of them died within one month of diagnosis.[12] Wood et al have stated that the mean survival time for untreated patients they studied having widespread metastases involving both lobes of the liver was 3.1 months.[13] The one-year survival rate was 5.7% (n = 87).

We are continuing to accrue patients to this series to extend our understanding of the values and shortcomings of continuous intravenous antitumor chemotherapy.

ACKNOWLEDGMENT. The authors wish to acknowledge Doctors Richard Rodgers, David Heber, Jack Harrington, and Mark Cicantelli for the referral of cases reported here.

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ABSTRACT

Fasciotomy: An appraisal of controversial issues

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Forty-eight fasciotomies performed for conventional indications were analyzed focusing primarily on the reliability of clinical diagnosis and the effectiveness of the operative technique. Decompression was accomplished immediately after hospital admission or arterial repair in 27 patients and deferred until the appearance of signs and symptoms in 21 others. Myoneural degeneration occurred in the delayed group only as a result of massive trauma or when obvious signs of compartment syndrome were ignored. A high index of suspicion and careful attention to clinical findings were reliable for establishing the diagnosis and indicating the timing of myofascial decompression. Tissue-pressure measurements were not used. The technique of four-compartment fasciotomy through a single lateral incision without fibulectomy was used in 21 limbs and compared with 18 four-compartment fasciotomies utilizing conventional methods. This procedure is rapid, simple, effective, and atraumatic and provides excellent exposure for direct visualization and selective decompression of all compartments and their individual muscles. ■

Constant intravenous insulin infusion during labor and delivery in diabetes mellitus

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We treated 30 diabetic women (31 pregnancies) during the peripartum period with a continuous insulin infusion. A mean infusion rate of 1.0μm/h maintained the mean plasma glucose concentration below 100 mg/dl in 84% of the patients; the plasma glucose concentration was below 100 mg/dl within an hour of delivery in 71% of the women. Mild hypoglycemia developed during the infusion in three women and after delivery in another patient. Only two infants of the diabetic mothers developed transient and asymptomatic hypoglycemia. We conclude that continuous insulin infusion is a practical, safe, and effective method for treating diabetic mothers during the peripartum period and suggest that this technique may decrease the frequency and severity of neonatal hypoglycemia. ■

Pneumococcal disease in a Wisconsin community hospital. . .

Thomas H Dee, MD and Carol S Berger, BS, Milwaukee, Wisconsin

ABSTRACT. *Surveillance of pneumococcal serotypes and spectrum of disease was done in a community hospital for 14 months. Ninety-six isolates from 54 patients were obtained. Type 3 was most frequently isolated (26%). There were 47 pneumonias, 17 involving two or more lobes. Thirteen (24%) bacteremias were detected. Ten were associated with pneumonia; six with multiple lobe involvement. There were six cases with extrapulmonary foci; the meninges being involved in three (50%) cases. Three of these cases were bacteremic. There were five deaths. Four deaths were associated with bacteremia; three with an extrapulmonary focus of infection. Eighty percent of all clinic isolates and all isolates from cases associated with bacteremia, extrapulmonary foci, or death were serotypes found in the new antipneumococcal vaccine.*

PNEUMOCOCCAL DISEASE continues to be a significant cause of morbidity and mortality. *Streptococcus (Diplococcus) pneumoniae* is still the etiology of approximately 70 to 80 percent of community acquired bacterial pneumonias. Mortality rates of approximately 25 to 35 percent have been reported in cases associated with bacteremia despite the availability of effective antimicrobial agents.[1,2,3] The recent emergence of resistant strains in various parts of the world may make the therapy of this "benign" organism more difficult.[4,5] The development and marketing of an antipneumococcal vaccine (Pneumovax®), consisting of 14 of the more commonly isolated serotypes, appears to hold promise as an effective modality in reducing morbidity and mortality.[6,7,8]

This paper reports the surveillance of pneumococcal serotypes and spectrum of clinical disease observed in a community hospital during a 14-month period just prior to the introduction of the antipneumococcal vaccine. It is anticipated that these data will serve as a baseline for future studies to determine whether the utilization of this vaccine will alter the morbidity and mortality, the etiologic serotypes, and clinical spectrum of pneumococcal disease.

From the Section of Infectious Disease, Department of Medicine, University of Wisconsin, Milwaukee Clinical Campus, Mount Sinai Medical Center, 950 North 12th St, PO Box 342, Milwaukee, Wis 53201 (phone: 414/289-8080). Reprint requests to Thomas H Dee, MD, at above address. Copyright 1982 by the State Medical Society of Wisconsin.

METHODS AND MATERIALS. Mt Sinai Medical Center is a 376-bed, acute care, community hospital with medical school affiliation. Its patient population represents a broad cross section of socioeconomic groups.

During the period between December 1976 and February 1978, all isolates identified by standard microbiologic techniques as *Streptococcus pneumoniae* were serotyped by either counterimmunoelectrophoresis or the Quellung reaction (Danish nomenclature).[9] The charts of all patients thus identified were reviewed for the following data: presence and extent of pneumococcal disease, underlying diseases or conditions, age, therapy, and outcome.

The diagnosis of pneumonia was based on the isolation of *Streptococcus pneumoniae* from purulent sputum and the presence of clinical and x-ray findings. Bacteremia was defined as the isolation of the organism from two or more sets of consecutively obtained blood cultures. Other disease states were defined based upon isolation of the organism from appropriate materials with concomitant clinical and other diagnostic findings.

RESULTS. There were 137 isolates of *Streptococcus pneumoniae* from 94 subjects during the 14-month study period. Of these, 96 isolates were obtained from 54 patients with clinical disease. The serotypes, diagnoses, and outcome for this group are summarized in Table 1.

Serotype 3 was most frequently isolated. It was present in 14 of 54 cases (26%). Other serotypes frequently isolated included: type 19, eight cases (15%), type 4, five cases (9%), type 9, five cases (9%). These four serotypes accounted for 59% of the total number of cases. The remainder were due to serotypes 6, 7, 11, 12, 15, 17, 18, 23, 25, 33, and 34. Only one case was secondary to a nontypable isolate.

Pneumonia was present in 47 cases of which 17 (36%) had two or more lobes involved. There were 13 cases (24%) of bacteremia. Ten of the bacteremias were associated with pneumonia. Six of these were in cases with multiple lobe involvement. In nine of the ten pneumonias with bacteremia, the organism also was isolated from the sputum. Three

TABLE 1—*Serotypes, diagnoses and outcome in 54 patients with pneumococcal disease*

Serotype	Diagnosis*	Outcome+	Serotype	Diagnosis	Outcome
3	P,B	S	11	BR	S
3	P	S	12	M,B,DIC	D
3	P,B	S	12	P	S
3	P,B,OM	D	15	P	S
3	P	S	15	P	S
3	M,B,BA,OM	D	15	P	S
3	P	S	17	P	S
3	P,B	S	17	P	S
3	P,B	S	18	P	S
3	P	S	18	BR	S
3	P	S	18	P	S
3	P,C	S	19	P	S
3	C	S	19	P	S
3	P	S	19	P	S
4	P	S	19	P	S
4	P,B	S	19	P	S
4	P,B	D	19	P	S
4	P	S	19	BR	S
4	P,B	S	19	P	S
6	P,B	S	23	P	D
6	M,E	S	23	P	S
6	P	S	25	P,B	S
7	P,B	S	27	P	S
9	P	S	33	P	S
9	P	S	34	P	S
9	P	S	NT	P	S
9	P	S			
9	P	S			

*Diagnoses: P-pneumonia, B-bacteremia, OM-otitis media, BA-brain abscess, C-conjunctivitis, M-meningitis E-endocarditis, BR-bronchitis, DIC-disseminated intravascular coagulation

+Outcome: S-survived, D-died

bacteremias were in cases with one or more extra pulmonary foci of infection. Six cases had one or more extrapulmonary foci including: meningitis (three cases), otitis media (two cases), conjunctivitis (two cases), brain abscess (one case) and endocarditis (one case). There were three cases of pneumococcal bronchitis.

Five deaths were attributable to pneumococcal disease. Of these four were bacteremic and three had extrapulmonary foci of infection. This represents mortality rates of 9% for all cases, 31% for bacteremic cases and 50% for cases with extrapulmonary foci.

Underlying disease or conditions were found in 28 cases and included: chronic obstructive pulmonary disease (12 cases), diabetes mellitus (six cases), chronic ethanol abuse (six cases), cancer of the lung (three cases), and one case each of ankylosing spondylitis, bronchiectasis, myelofibrosis, cancer of the larynx, and silicosis. Three patients had more than one existing problem. Of the five deaths, two were in patients with underlying problems; one case each of diabetes mellitus and chronic ethanol abuse.

Ages ranged from 23 to 88 years with a mean age of 56 years. Nine of 13 bacteremic cases, four of six cases with extrapulmonary foci and four of five deaths occurred in patients >50 years old. Males accounted for 36 (67%) of the cases.

One or more appropriate antimicrobial agent was used in each case. When indicated, measures to support the cardiovascular, respiratory and/or renal systems were employed.

There were 41 isolates of *Streptococcus pneumoniae* in 40 subjects found to be disease-free. It is of interest to note that 16 of the isolates (39%) were not typable. One patient had two serotypes isolated simultaneously. All isolates were from sputum or throat culture specimens.

DISCUSSION

The results of this retrospective study in adult patients demonstrates that bacteremic pneumococcal disease, especially when associated with an extrapulmonary focus of infection, continues to carry a significant mortality rate despite available antimicrobial and supportive therapy. Our mortality rate for bacteremic cases of 31% is not unlike the 25% rate of Austrian and Gold, 35% of Dorff et al, and 28% of Mufson's group.[1,2,3]

The most frequently isolated pneumococcus was serotype 3. This serotype was found in 26% of the total cases, in six (46%) of the bacteremias, and four (67%) cases with an extrapulmonary focus. Other frequently isolated serotypes were 19, 4, and 9. Together these four serotypes accounted for 59% of the total cases. During the pre-antibiotic era, serotype 3 was one of the most frequently isolated serotypes in bacteremic disease.[10] However, in the reviews of Austrian and Gold and Mufson, et al, this serotype was isolated in only nine and 6% of bacteremic cases respectively.[1,3]

Bacteremia occurred in 24% of our cases. This figure is comparable to the rates reported by others.[1,2] Bacteremia was more likely to be present in pneumonias with multiple lobe involvement and cases associated with an extrapulmonary foci of infection. The isolation of the *Streptococcus pneumoniae* from the sputum in nine of ten pneumonias associated with bacteremia suggests that examination of sputum specimens is a useful procedure in the diagnosis of pneumococcal pneumonia.[11]

The most frequent site of extrapulmonary infection was the meninges, found in three of the six cases. In no case was pneumonia present. This has been the most frequent site reported by others.[1,3]

The presently available polyvalent pneumococcal vaccine contains the following serotypes (Danish nomenclature): 1, 2, 3, 4, 6, 7, 8, 9, 12, 14, 18, 19, 23, and 25. Our data show that 81% of the total cases were caused by serotypes found in this preparation as were all of the bacteremias, cases with extrapulmonary sites of infection and fatalities.

Based on these results and the results of other studies, we urge the use of pneumococcal vaccine especially in individuals 50 years old, regardless of the presence or absence of underlying disease.

ACKNOWLEDGMENT: The authors are grateful to Susan Butcher for her secretarial assistance in the preparation of this manuscript.

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ABSTRACT

Septic endarteritis due to intra-arterial catheters for cancer chemotherapy

I. Evaluation of an outbreak. II. Risk factors, clinical features and management. III. Guidelines for prevention

DENNIS G MAKI, MD; RITA D MC CORMICK, RN; STEPHEN J UMAN, MD, and GEORGE W WIRTANEN, MD (University of Wisconsin Hospital and Clinics, Center for Health Sciences, Madison, Wis) *Cancer* 44:1228-1240 (Oct) 1979

A cluster of three cases of staphylococcal septic endarteritis originating from percutaneously inserted brachial artery catheters for regional cancer chemotherapy prompted an epidemiologic and clinical study of bacteremic infections associated with this therapeutic modality. Nine cases were identified over a 3½-year period (1.6% of all catheterizations), all caused by *Staphylococcus aureus*. The cluster followed discontinuation of hexachlorophene for scrub of the extremity prior to cannulation; phage-typing suggested the three cases were caused by the patients' own strains of *Staphylococcus*. These infections produced a distinctive clinical syndrome which facilitates implicating the catheter in the genesis of fever occurring in a patient receiving intra-arterial chemotherapy: early localized pain (89%) and hemorrhage (78%), and Osler's nodes distally (44%), later followed by local inflammation (78%), purulence (56%) and signs of systemic sepsis (100%) (each factor, $p \leq .005$). Duration of cannulation did not influence susceptibility to infection. However, difficult cannulations or need for repositioning the catheter, prior radiation therapy, leukopenia and hypoalbuminemia were all associated with septicemia. In the 25 months since implementation of specific control measures, there have been no further catheter-related septicemias in 310 catheterizations.

Following the fourth case in May 1975, a program of itensified surveillance for IA catheter-related infection was put in effect and the preparatory scrub of the patient's arm with hexachlorophene was resumed. In addition, a topical combination antibiotic ointment containing Polymyxin, neomycin and bacitracin (Neosporin®, Burroughs-Wellcome) was applied to the catheter site at the time of initial insertion and at all subsequent remanipulations. During 1976 and 1977, further procedures and modifications of existent practices were implemented: (1) a total body hexachlorophene shower the night prior to cannulation, (2) ethylene oxide sterilization of precut catheter segments, (3) discontinued use of quaternary ammonium detergent in catheter preparation, and (4) semi-quantitative culturing of catheters on removal. Physicians and nurses assigned to the oncology units have received inservice training which emphasizes the early signs and symptoms of catheter-related infection.

Since June 1, 1975, no staphylococcal septicemias of any etiology and no catheter-related septicemias specifically have occurred in patients on the three units, during which time 310 arterial cannulations for regional chemotherapy have been performed. ■

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Management of footling breech presentation

Luis B Curet, MD, Madison, Wisconsin

EDITORIAL NOTE: *The following article is one of the few studies published on management of the footling breech. Although absolute recommendations cannot be made, the article provides information and guidelines that can be useful to the obstetrical practitioner. —LBC*

CONSIDERABLE CONTROVERSY exists around the issue of breech delivery. As a result of poorly designed studies, no study has clearly settled the issue of how best to deliver the infant presenting as a breech. Few of the published studies have dealt with the footling breech separate from the other types of breech presentations. In one recent study[1] 19 patients with a footling breech presentation were given a trial of labor. Perinatal mortality, head entrapment, and cord prolapse occurred only in the very low birth weight infants (<1500 gm). The authors recommended that the premature footling breech infant, especially those weighing between 1000-1500 gm, be managed by Cesarean section.

We have recently reviewed our experience with footling breech deliveries at the University of Wisconsin Perinatal Center at Madison General Hospital. From 1978-1980 there were 71 infants delivered presenting as footling breeches. Thirty-five of those patients received a primary Cesarean section and 36 were given a trial of labor after being admitted with the cervix already partially dilated. The outcomes of those 36 patients were as follows:

1. Twenty-two (61%) delivered vaginally.
2. The number of Apgar scores less than 7 at one and five minutes was not different from the Cesarean section group.
3. The total perinatal mortality was higher (17%) than in the Cesarean section group. However, 83% of the deaths occurred in infants less than 30 weeks. There were no deaths in infants more than 37 weeks and only one between 30-36 weeks.
4. Eight patients (22%) had prolapse of the umbilical cord. Two of those babies died. One of these babies was at 26 weeks gestation and the other at 36. The latter one was severely growth retarded, had a true knot and only two vessels in the umbilical cord. The infant also had hypothyroidism and died neonatally with hypotension and oliguria. Autopsy was not performed.
5. One infant at 26 weeks had head entrapment.

Based on the above information it would appear that a trial of labor can be safely considered if the patient is dilated on admission and anesthesia back up is in house and the operative suite is immediately available. If these conditions cannot be met, a Cesarean section is advisable. It would seem that in patients at less than 30 weeks gestation there might be an advantage to delivery by Cesarean section. We are in the process of evaluating that alternative before a definite recommendation can be made.

From the Department of Obstetrics and Gynecology, University of Wisconsin, and the Wisconsin Perinatal Center, Madison General Hospital, Madison, Wisconsin. Publication support provided. Reprint requests to: Luis B Curet, MD, Dept of Obstetrics and Gynecology, Madison General Hospital, 202 South Park St, Madison, Wis 53715 (phone: 608/267-6000). Copyright 1982 by the State Medical Society of Wisconsin.

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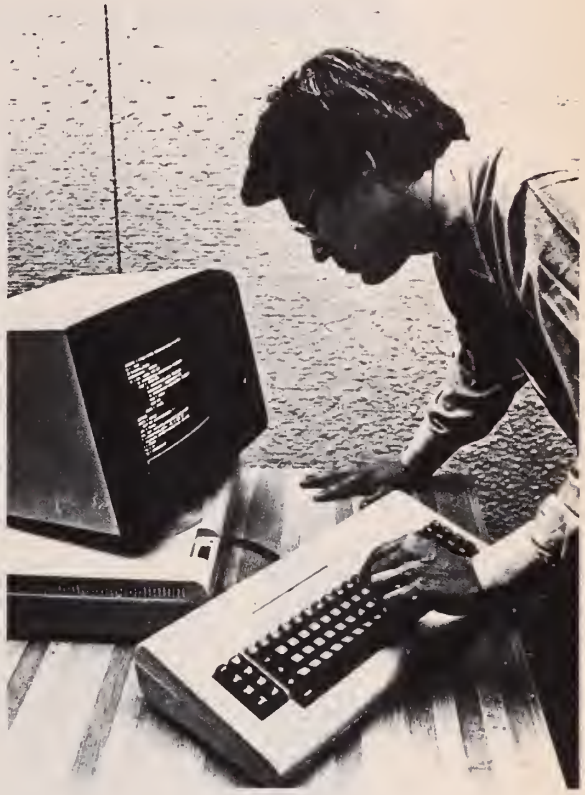

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Nominating Committee presents slate of candidates

Meeting in Madison September 27, 1981, the Nominating Committee of the SMS House of Delegates chose the following slate of candidates for positions to be filled by House of Delegates' elections on Friday, May 14, during the State Medical Society's Annual Meeting, May 13-15, in Milwaukee at the MECCA and Hyatt Regency:

President-elect: Chesley P Erwin, MD, Milwaukee.

Vice-speaker of the House: Vernon M Griffin, MD, Mauston.

Treasurer: John J Foley, MD, Menomonee Falls.

AMA Delegates for calendar years 1983-1984 to succeed themselves: John K Scott, MD, Madison; Patricia J Stuff, MD, Bonduel; and DeLore Williams, MD, West Allis.

AMA Alternate Delegates for calendar years 1983-1984 to succeed themselves: Cornelius A Natoli, MD, La Crosse; John D Riesch, MD, Menomonee Falls; and Walter J Woloschek, MD, Milwaukee.

The meeting was chaired by Sandra L Osborn, MD, Madison. James J Tydrich, MD, Richland Center, is the secretary. Members of the committee, listed on page 39 of this issue, will be meeting again following the First Session of the House of Delegates, May 13.

Candidates' pictures and biosketches appear in this issue on pages 37-38-39. ■

CES FOUNDATION

CONTRIBUTIONS—DECEMBER 1981

The Charitable, Educational and Scientific Foundation of the State Medical Society is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for December 1981.

Unrestricted

GP Ferrazzano, MD; Vyta K Kerpe, MD; VA Baylon, MD; George A Behnke, MD; Wilson J Troup, MD; Kandavar Gopal, MD; Waldemar W Wolfmeyer, MD; John W Beasley, MD; Elmore P Huth, MD; SMS Members—*Voluntary Contributions*

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Lon D Babbitt, MD—*Student Loan Fund*

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Rick Austin—*Terry Ann Olsen (Brown County Loan Fund)*

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John C & Mary Lou LaBissoniere—*Arthur G Spoerl* ■

Annual Meeting Scientific Program about completed; mailing soon

The Scientific Program for the Annual Meeting is in final stages of production and will be mailed to members shortly.

Another excellent program has been organized by the Commission on Continuing Medical Education.

Highlights include two panels on Friday, May 14. A panel on "Mental Retardation (identification and long-term management of retarded children: emotional factors—screening and testing modalities—community resources)" will be held from 9 to 12 noon. A panel on "A Review of Current Concepts in Adolescent Development, Sexuality, Contraceptive Decision-making, and Complications of Pregnancy" will be held from 1:45-4:45 pm. Both panels will be acceptable for 3 hours in Category 1 for AMA-PRA and 3 hours prescribed credit by AAFP.

Three panels will be held on Saturday, May 15. A panel on "Adolescent Alcoholism and Drugs" will be acceptable for 2 hours of credit in Category 1 of AMA-PRA and 2 hours prescribed credit by AAFP. It will be held from 8-10 am. From 8-10:30 am another panel will be held on "Adolescent Suicide, Violence, and Other Problems." It will be acceptable for 2.5 hours of Category 1 credit by AMA-PRA and 2.5 prescribed credit hours by AAFP. A panel on "Cardiovascular Problems in the Adolescent" will be held from 10:15 am-12 noon. It is acceptable for 2 hours of Category 1 credit by AMA-PRA and 2 prescribed credit hours by AAFP.

Other events include a program on "Women in Medicine" starting at 5:30 pm Friday, May 14, for a social hour, dinner, and program.

Featured on Saturday morning, from 9 to 12 noon will be a program on "The Politics of Organized Medicine." Speakers will be Russell Miller of Moss, Miller, and Josephson, Chicago, an authority on parliamentary procedure, and Nancy W Dickey, MD, Rosenberg, Texas, a member of the AMA Judicial Council.

An HMO-IPA Conference has been scheduled for Thursday, May 13, from 3-6 pm. The Presidents' Reception and Dinner will be held that evening starting at 7 pm. ■

Three district caucuses set

Caucus dates have been set in three SMS Board of Directors districts to review resolutions and other business relating to the forthcoming Annual Meeting of the State Medical Society of Wisconsin May 13-15, 1982. Physicians who would like to attend should contact the SMS Physicians Alliance office in Madison to secure a reservation. Dates, times, and locations for the caucuses are as follows:

THIRD DISTRICT—Pauline Jackson, MD, Director
Monday, April 19, 1982, New Villa, La Crosse
Caucus—5:00 pm, cocktails—6:30 pm, dinner—7:00 pm
District meeting following dinner

SEVENTH DISTRICT—Paul S Haskins, MD, Director
Thursday, April 22, 1982, Holiday Inn, Eau Claire
Dinner and meeting at 6:30 pm

EIGHTH DISTRICT—Joseph M Jauquet, MD, Director
Wednesday, April 21, 1982, Scottie Club, Ashland
Cocktails at 6:30 pm
Dinner and meeting at 7:00 pm■

Slides needed for slide tape presentation

SMS is looking for color slides showing physicians at work for use in developing a slide-tape program on careers in medicine. The Wisconsin Council of Professions has asked each of the professions to produce an audio-visual program for high school student education on vocations. Physicians who could lend slides to be duplicated for this project should contact: Diane Upton or Earl Thayer at SMS offices in Madison, 330 E Lakeside St, Madison, WI 53715; phone 608/257-6781 or toll-free: 800/362-9080.■

Address change

SMS Physicians Alliance field consultant Kris Bjurstrom now has a new address: 79 University Drive, Fond du Lac, WI 54935. Ms Bjurstrom serves as a field consultant to Florence, Marinette, Oconto, Shawano, Waupaca, Outagamie, Brown, Door, Kewaunee, Manitowoc, Sheboygan, Calumet, Fond du Lac, and Winnebago counties. Physicians can reach her by phone at 414/921-4407.■

SMS annuity unit value $3.46

The SMS variable annuity contract accumulation unit value, applicable to the SMS-sponsored retirement (Keogh) plan for self-employed physicians was $3.46 as of December 31, 1981.■

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Here is a slate of those candidates chosen for top State Medical Society offices by the Committee on Nominations. This is the slate on which the House of Delegates will vote at the Society's Annual Meeting May 13-15 at Milwaukee's Exposition and Convention Center and Arena (MECCA) and Hyatt Regency. Be sure to let your county medical society delegate know your preferences in the next few weeks.

Incoming President
Gerald C Kempthorne, MD
Spring Green

Nominees for SMS offices; election May 14

☐ Chesley P Erwin, MD

President-elect (1982-83)

Graduated from the School of Medicine, University of Oklahoma in 1951. Interned at Harris Hospital, Fort Worth, Tex, from 1951-52 and residency in pathology at Milwaukee County General Hospital, 1952-55 and Lutheran Hospital, Milwaukee, 1955-56. Served in the United States Armed Forces, 1942-46. Board certified in Anatomic and Clinical Pathology in 1956; certified in subspecialty in Forensic Pathology in 1976. Is professor of pathology at the Medical College of Wisconsin, and also is medical examiner of Milwaukee County, serving since 1972 to the present. Is fellow of College of American Pathologists, American Society of Clinical Pathologists, and the American Academy of Forensic Sciences. Is member of the International Academy of Pathology, International Association of Coroners and Medical Examiners, New York Academy of Sciences, Milwaukee Academy of Medicine, American Association for the Advancement of Sciences, Wisconsin Coroners Association, Wisconsin Society of Pathologists, and National Association of Medical Examiners. Served as president of The Medical Society of Milwaukee County, 1976; president of the Wisconsin Society of Pathologists, 1971-73; and president, Faculty Assembly, Medical College of Wisconsin from November 1970 (inception) until July 1971. Is member of Council and past president of Milwaukee Academy of Medicine; member, Board of Directors, Foundation for Medical Care Evaluation of Southeastern Wisconsin, Inc; member, University of Wisconsin System Medical Technology Advisory Committee; and vice-chairman of WISPAC, 1979-1981. Is member of the Board of Directors of the State Medical Society of Wisconsin and vice-speaker of its House of Delegates, 1981-82. Served on the medical staff of Family Hospital, Milwaukee, from 1956-66 and presently is on the staff of Milwaukee County General Hospital, since 1966.

☐ Vernon M Griffin, MD

Vice-speaker of House of Delegates (1982-84)

Born in 1926 in North Dakota, he received a BA degree from the University of North Dakota and graduated in 1938 from the University of Oregon Medical School in Portland. Member of the honor societies of Phi Beta Kappa, Sigma Xi, and Alpha Omega Alpha. Interned at Ancker Hospital, St Paul, Minn, and served surgical preceptorship in Grand Forks, North Dakota. Served in the United States Army Medical Corps from 1941-46. Licensed in Wisconsin in 1946. Member of active medical staff of Hess Memorial Hospital in Mauston from 1946 to present and served on various committees and also past chief-of-staff. He was president and chairman of the board of directors of Hess Memorial Hospital from 1962-81. Member and one year as chairman Reference Committee on Credentials SMS House of Delegates, 1976-77; member 1978 and chairman Reference Committee on Finance of SMS House of Delegates, 1979; and member and one year as chairperson Nominating Committee of SMS House of Delegates, 1977-81. Member of Juneau County Medical Society and a delegate to the State Medical Society since 1950.

☐ John J Foley, MD

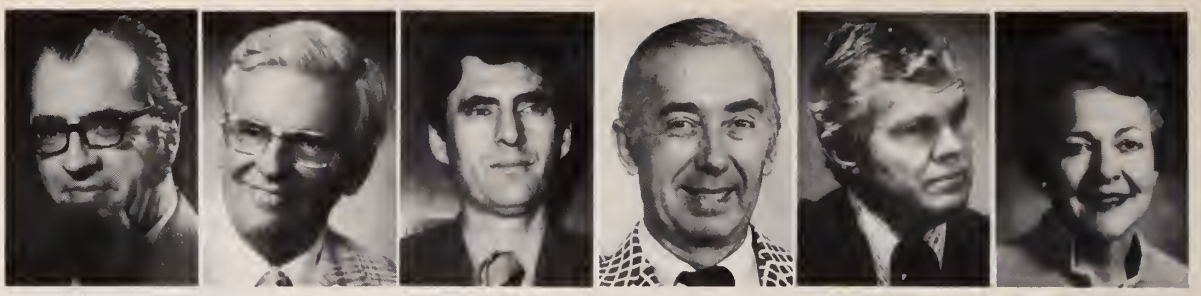
Treasurer (1982-83)

Born in Chicago, Ill, he graduated from Stritch School of Medicine, Chicago, 1956. Internship and residency completed at Milwaukee County General Hospital, 1956-57 and 1959-63. Served in the United States Air Force, 1957-59. Licensed to practice medicine in Wisconsin, 1959. Certified by American Board of Surgery, and fellow, American College of Surgeons. Is associate professor of Surgery, Medical College of Wisconsin, Milwaukee. Served as SMS Councilor (now Director) from District I, 1972-1981, and as treasurer of SMS, 1981-82. Serves as *ex-officio* member of SMS Finance Committee of the Board of Directors, and is member of SMS Realty Corporation Board of Trustees. Also member of the Board of Directors of SMS Services, Inc.

☐ John Kimball Scott, MD

Delegate to American Medical Association (1983 & 84)

Graduate of Ohio State University College of Medicine, 1954. Internship, White Cross Hospital, Columbus, Ohio, 1954-55; otolaryngology residency at University Hospitals, Columbus, Ohio, 1955-58. Licensed to prac-



Doctor Erwin | Doctor Griffin | Doctor Foley | Doctor Scott | Doctor Williams | Doctor Stuff

tice medicine in Wisconsin, 1958. Certified by American Board of Otolaryngology, 1959. Clinical Professor of Otolaryngology at University of Wisconsin Medical School. On staffs of St Mary's, Madison General, and University hospitals, Madison. Preceptor for fourth year residency program, Madison General Hospital. President, Dane County Medical Society, 1975. Delegate from Dane County Medical Society to the State Medical Society of Wisconsin, 1972-present. Alternate delegate to the AMA, 1977-78, delegate to the AMA, 1979-82. Member Reference Committee of AMA, 1979, and chairman 1982. Member, State Medical Society House of Delegates Reference Committee on Reports of Standing Committees, 1971 and chairman, 1972 and 1973. State Medical Society Committee on Cancer, chairman since 1971. Member, SMS Committee on Medicine and Religion. Secretary-treasurer of WISPAC. National delegate to American Cancer Society since 1972; President, American Cancer Society-Wisconsin Division, 1972. President of Wisconsin Otolaryngology Society, 1974. Fellow, American College of Surgeons, 1962. President, Wisconsin Chapter of the American College of Surgeons, 1978-79. Member, American Academy of Ophthalmology and Otolaryngology since 1960. Chairman of Commission on Cancer, Wisconsin Chapter of American College of Surgeons. Member, Society of Head and Neck Surgeons, 1963. Member, American Laryngological, Rhinological and Otological Society, 1972. Chairman of Board, WisPRO. Team physician for sports, West High School, Madison.

☐ DeLore Williams, MD

Delegate to American Medical Association (1983 & 84)

Graduate of the former Marquette University School of Medicine. Interned at Milwaukee's Columbia Hospital, 1948-49, with residency training at VA Hospital, Milwaukee, 1949-51 and 1953-54. Licensed to practice medicine in Wisconsin, 1949. Prior to completing residency, served in the US Air Force. Certified by American Board of Internal Medicine, 1957. Practices in West Allis and is clinical instructor at Medical College of Wisconsin. Was chairman of SMS Ad Hoc Committee on Quackery. Served as 12th District and 1st District SMS Councilor (now Director), 1971-77. Served on former Commission on Public Policy as regular member between 1971 and 1972 and ex officio member between 1973 and 1978. Was member of Council's Finance Committee, 1971-77. Also member of Wisconsin Society of Internal Medicine, American College of Physicians, and American Society of Internal Medicine. Delegate to State Medical Society since 1972. Delegate to AMA, 1977-82. Member of The Medical Society of Milwaukee County and served on Legislative Policy Committee, chairman for four years; served on county society's Editorial Board and Medical School Liaison Committee; and also served on Long-range Planning Committee three years. Served as member of West Allis Memorial Hospital's Board of Directors, and member of Finance Committee, Public Relations Committee, Quality Care Committee and Long Range Planning Committee. Also chairman of its Development Council. Served as member of West Allis Chamber of Commerce Board of Directors from 1962-74 and was president of Chamber of Commerce, 1963. Member of Board of Directors of Central Bank, West Allis, 1973 to present.

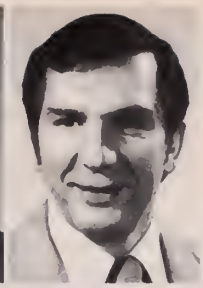
☐ Patricia J Stuff, MD

Delegate to American Medical Association (1983 & 84)

Graduate of Woman's Medical College. Received internship at St Luke's Hospital, Chicago, Ill, 1955 to 1956. Served residency at Sacred Heart Hospital, Yankton, SD, 1956 to 1957. Received license to practice medicine in Wisconsin in 1957. Began general practice of medicine in Bonduel same year. Has been delegate to State Medical Society of Wisconsin from Shawano County Medical Society, 1966-1973 and alternate delegate in 1977-1978. Became vice-speaker of House of Delegates in 1973 and speaker of House of Delegates, 1975-1977. Also has served as member of State Medical Society's Nominating Committee and of House of Delegates reference committees. Member of board of directors of Wolf River Mental Health Clinic, founded by citizens' committee she organized in 1964. Headed clinic's board of directors in 1966. Served as vice-chairman of Unified Mental Health Board of Shawano and Waupaca counties and chairman of its planning committee 1974-1975. Is chairman of credentials committee of Shawano Community Hospital. Was recipient of "Woman of the Year" award by Shawano County Business and Professional Women's Association in 1971 and is listed in *Who's Who of American Women*. Serves as Adjunct Professor, University of Wisconsin-Oshkosh, 1975 to present. Member of SMS Ad Hoc Committee on Women's Health Issues, 1979. AMA alternate delegate 1977-1978 and AMA delegate 1979 to present. Chief teller at 1979 AMA Annual Meeting, and appointed to chair AMA Ad Hoc Committee on Women Physicians in Organized Medicine, September 1979. Chairman of SMS Committee on Women Physicians 1981 to present.

Doctor Natoli

Doctor Riesch


Doctor Woloschek

☐ **Cornelius A Natoli, MD**

Alternate Delegate to American Medical Association (1983 & 84)

Born in Utica, New York, 1930, he received BS degree in 1952 from Niagara University, and graduated in 1956 from Georgetown University School of Medicine. Internship and residency in surgery at Barnes Hospital, St Louis, Missouri, followed by three years of urology residency at Barnes Hospital. Private practice in Salt Lake City, Utah, from 1961-1969; held offices in Utah State Medical Association, Public Health Committee, and Utah Urological Society. Member of Gundersen Clinic, Ltd, from 1969 to present. Clinical assistant professor of surgery (urology), University of Wisconsin Medical School. Is past president of LaCrosse County Medical Society; member of American Urological Association, Wisconsin Urological Society, and American College of Surgeons, and North Central Section of AUA. Past chairman LaCrosse County Insurance Advisory Committee; past member of SMS House of Delegates and served on its Reference Committee on Finance and chaired Reference Committee on Reports of Officers; member of past SMS Commission on Medical Care Plans, and was a member of WPS Board of Directors; past member of SMS House of Delegates Nominating Committee; and served as Third District Councilor of SMS. Is a member of WisPAC. Also member of Board of Directors, Gundersen Clinic, Ltd.

☐ **John D Riesch, MD**

Alternate Delegate to American Medical Association (1983 & 84)

Graduate of University of Wisconsin Medical School in 1958. Internship and residency at Milwaukee County General Hospital, 1958-1963. Is assistant clinical professor of surgery, Medical College of Wisconsin. Hospital affiliations as a general surgeon: Community Memorial, Menomonee Falls (chief of staff, 1969-1970; chief of surgery, 1971-1972); Elmbrook Memorial, Brookfield; St Joseph's, Hartford (consulting staff); Waukesha Memorial, Waukesha (associate staff); and West Allis Memorial, West Allis. Received Distinguished Alumni Award of Whitewater University, 1972; and became a member of its Hall of Fame, 1973. Served as president of Waukesha County Medical Society in 1973-1974; member of Milwaukee Academy of Surgeons; Wisconsin Surgical Society; Medical Society of Milwaukee County (associate member); American College of Surgeons, president of Waukesha Cancer Society, 1969-1970, and member of Wisconsin Board of Medical Examiners in 1969. Certified by American Board of Surgery in 1965; received fellowship in American College of Surgeons, 1966. Member of SMS Commission on Mediation and Peer Review and House of Delegates Nominating Committee. Member of Wisconsin Review Foundation. Appointed board examiner for American College of Surgeons, on medical panel of Menomonee Falls Police and Fire Commission, and on disaster committee of Community Memorial Hospital.

☐ **Walter J Woloschek, MD**

Alternate Delegate to American Medical Association (1983 & 84)

Born in Milwaukee, 1928, he graduated from Marquette University School of Medicine in 1954. Interned at St Mary's Hospital, Milwaukee, and residency in surgery at Milwaukee County General Hospital. Licensed in Wisconsin in 1955. Diplomate, American Board of Surgery, 1961, and fellow in American College of Surgeons. Is an associate clinical professor of surgery at Medical College of Wisconsin and on active staff of St Luke's Hospital where he was chief of surgery, 1970-71. Also on consulting staff of St Mary's Hospital and Veterans Administration Hospital in Wood. Served as chief of surgery at St Mary's, 1968-69. Was recipient of "Excellence of Surgical Education Award, Walter Schroeder Chair of Surgery, 1977." Was president-elect of The Medical Society of Milwaukee County in 1979 and served as president in 1980. Member of board of directors of The Medical Society of Milwaukee County. Member of Milwaukee Academy of Surgery (president, 1971); member of Wisconsin Surgical Society; Milwaukee Surgical Society, and the Wisconsin Chapter of the American College of Surgeons. Is delegate to State Medical Society of Wisconsin and alternate delegate to American Medical Association. ■

House of Delegates Nominating Committee

District 1: *Clifton E Peterson, MD,* Kenosha
John D Riesch, MD, Menomonee Falls
Kenneth M Smigielski, MD, Milwaukee
Jerome J Veranth, MD, Racine

District 2: *Sandra L Osborn, MD,* Madison (chair)
James J Tydrich, MD, Richland Center (secretary)

District 3: Vacancy

District 4: *John E Thompson, MD,* Nekoosa

District 5: *Kenneth M Viste Jr, MD,* Oshkosh

District 6: *John E Kraus, MD,* Marinette

District 7: *Merne W Asplund, MD,* Bloomer

District 8: *Clarence M Scott, MD,* Superior

Specialty Sections: *Joel E Taxman, MD,* Milwaukee

SMS advisory committee on Medicaid begins work

A special advisory committee to the Wisconsin Department of Health and Social Services has held its first two meetings and has begun work on reviewing DHSS data on physician reimbursement. Established by the SMS Board of Directors, the committee was appointed at the request of the Department.

DHSS staff have begun to develop reports for the committee relative to the range of physician charges to the T-19 program as well as information that summarizes the array of charges that have been identified as the most frequently billed procedures.

Thus far the committee has reviewed only background material on Wisconsin as well as other midwestern states. More detailed information specific to Wisconsin is due in time for the next meeting of the committee in late March.

DHSS requested the appointment of the advisory panel in anticipation of the establishment of a "uniform" reimbursement methodology later this year. ■

LEGISLATIVE UPDATE

The Assembly Committee on Health and Human Services February 23 endorsed a measure allowing chiropractors to refer patients to hospitals for outpatient diagnostic x-ray or laboratory services.

Assembly Bill 882, as amended, would apply only to those hospitals which allow outpatient referrals to any person who is not an active member nor associate member of the hospital's medical staff. The substitute amendment continues to contain the requirement that hospitals provide a report of the test results to the referring chiropractor.

Assembly Bill 882 and its counterpart, Senate Bill 632, are both available for scheduling for floor action. The State Medical Society is ***strongly opposed*** to this measure and is mounting a fight against it in both houses.

In other legislative action during February:

• The State Senate passed a substitute amendment to SB 437 which would require physicians to properly label prescription drugs and to maintain proper records of drugs dispensed according to rules promulgated by the Medical Examining Board. Violation of the dispensing laws would subject physicians to disciplinary action by the Medical Examining Board. The substitute amendment is an agreed-upon proposal worked out by bill sponsor Senator Gary Goyke, the Pharmacy Examining Board and the State Medical Society.

• The State Assembly passed AB 728 which authorizes school personnel to administer drugs to pupils in compliance with the written instructions of a physician, podiatrist, or dentist, provided the pupil's parents consent in writing. ***SMS supports.***

• The State Senate passed SB 222 which restricts the sale, use, distribution, possession, and advertising of drug paraphernalia. ***SMS supports.***

• The State Assembly tabled AB 710 which contains a provision authorizing the Dept of Regulation and Licensing to issue temporary physician licenses. ***SMS opposes.***

• The State Senate passed SB 578 which would add mumps to the state's immunization program for school-age children. Immunizations are required for admittance to nursery school through grade 12, unless a parent submits a written waiver objecting the immunization for reasons of health, religion, or personal conviction. ***SMS supports*** this bill which must still pass the Assembly. ■

Dr Kempthorne interviewed on medical audit committee report

CBS News came to the State Medical Society offices February 17 to interview SMS President-elect Gerald Kempthorne, MD for more than an hour concerning the role of a Society committee in Dept of Health and Social Services (DHSS) policy prohibiting payment for experimental procedures under Medicaid.

DHSS has a contractual arrangement with the Society Medicaid Medical Audit Committee headed by Doctor Kempthorne and periodically seeks advice on the "appropriateness, quality, and quantity of medical care provided to Medicaid recipients."

In March 1981 the committee advised DHSS that several procedures, including heart transplants, were experimental and the Department subsequently refused to pay for such procedures.

A Medicaid recipient in Milwaukee who is seeking a heart transplant is currently challenging that determination. ■

Automatic licensure proposal rejected

A task force created by Dept of Regulation and Licensing Secretary Ann Haney defeated a proposed resolution which would have given examining boards the authority to grant automatic licensure to persons who had graduated from an approved program within the last six months prior to application. No examination would be required for state licensure.

Representatives of the ten state-regulated health professions rejected the proposal on the grounds that academic credentials do not necessarily assure that an individual is able to deliver quality medical care on a one-to-one basis.

The task force also considered a resolution to allow the examining board to license on the basis of "comity," or in other words, to legally recognize the licenses issued by other states. After motions were made both to table and defeat the concept, the Task Force directed Dept of Regulation and Licensing staff to rewrite the resolution to call for "reducing unnecessary or arbitrary restrictions on out-of-state licentiates." ■

Child seat restraint bill gets boost

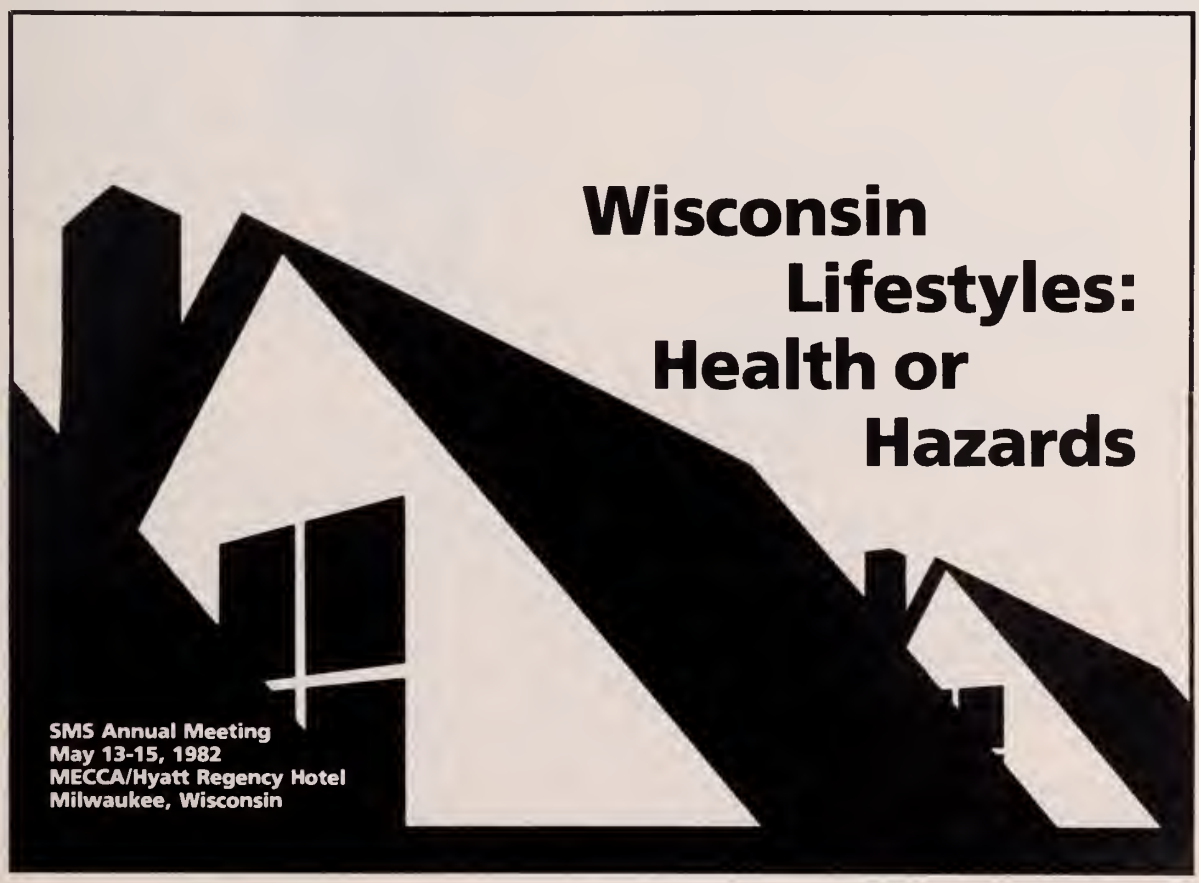
The State Assembly has passed a bill which would make it illegal for parents to transport their children under two years old without a restraining device approved by the State Dept of Transportation. The bill also requires children under 4 to be restrained in at least a seat belt. Penalty provisions would be waived if proof of purchase or lease of an approved seat restraint is provided within 30 days. The bill now goes to the State Senate for action.

In a related action, SMS representatives February 17 spoke in favor of the Senate's version of the measure, SB 709, at a public hearing.

Legislative Coordinator Don Lord pointed out to members of the Senate Transportation Committee that protective laws are the only practical approach toward "immunizing" the majority of young children against their number one epidemic—death and serious injuries on the highway.

"Children are dependent passengers, incapable of making decisions on their own to protect themselves," Lord said. "Because of this vulnerability, it is necessary that the Legislature write a law to protect them." ■

PR KIT ON HYPERTENSION PREVENTION OFFERED. A kit of public information materials on hypertension is available from the National Heart, Lung, and Blood Institute in connection with the observance of "National High Blood Pressure Month" in May. The kit is aimed at helping physicians muster support for the observance from decision-makers, the media, consumers, and patients. For additional information and copies of the kit, write High Blood Pressure Month 1982, High Blood Pressure Information Center, 120/80 National Institutes of Health, Bethesda, MD 20205. ■



Physician Briefs

*Physician members of State Medical Society of Wisconsin

Thomas Winters, MD, Wautoma, recently became associated with the medical staff of Marshfield Clinic-Wautoma Center. Doctor Winters graduated from the University of Wisconsin Medical School and completed his family practice residency at St Mary's Hospital, Grand Rapids, Mich. Prior to joining the medical staff of Marshfield Clinic, Doctor Winters had served as an emergency room physician at St Mary's Hospital in Grand Rapids, Mich.

Paul F Biere, MD, Hollandale, recently became a member of the Hollandale Family Practice Clinic. Doctor Biere graduated from the University of Iowa Medical School and completed his family practice residency in New Jersey.

Ira Kastenberg, MD, Poynette, recently joined the medical staff of the Poynette Family Practice Center. He graduated from the State University of New York Medical School in Syracuse and completed his family practice residency at Deaconess Hospital in Milwaukee.

Luis L Galang, MD,* New London, has been elected president of the New London Community Hospital's medical staff. Other officers elected are MDs David A Hammes,* vice-president, and Donn D Fuhrmann,* secretary-treasurer. Doctor Galang succeeds Lloyd P Maasch, MD* as president. Terms of office are for 1982 and 1983.

Bill Cushing, MD, Green Bay, recently became associated with the Hittner Clinic in Seymour. Doctor Cushing graduated from Wayne State University School of Medicine, Detroit, Mich, and completed his internal medicine residency at Henry Ford Hospital in Detroit. Doctor Cushing practiced medicine in Alpina, Mich, and in Columbia, Ky, prior to joining the Hittner Clinic.

Melvin F Huth, MD,* Baraboo physician and sports enthusiast of local high school athletic events and the neighboring areas, recently was honored at the 30th Annual Blue and Gold Basketball Game in Baraboo. Doctor Huth was presented with a basketball with the players names inscribed on it. He has been the organizing force in arranging the WIAA physicals for all of the 39 years he has practiced in the Baraboo area.

Michael L McCann, MD,* Middleton, recently was honored as Middleton's "Business Person of the Year." Doctor McCann was selected by the Middleton Chamber of Commerce, which presented the award at its annual banquet. The Middleton pediatrician also shared the "New Business Structure" award with his partners for a professional building. Doctor McCann was selected for the business person award because of his community work.

Teodoro Romana, MD, Wild Rose, recently joined the medical staff of the Wild Rose Medical Clinic. Doctor Romana graduated from Far Eastern University, Institute of Medicine, Manila, The Philippines, and served his internship and residency at Fordham and Misericordia Hospital, Bronx, NY. Prior to joining the Clinic, Doctor Romana had practiced in New York and Michigan. While in Michigan he was chief-of-staff at Community Hospital in Douglas and also was on the medical staff of Holland Community Hospital in Holland, Mich.

Steve Immerman, MD, Eau Claire, has joined the medical staff of Sacred Heart Hospital in Eau Claire. He graduated from Northwestern University Medical School, Chicago, and completed his internship at Northwestern Memorial Hospital. He served his residency in surgery at Northwestern University and was a fellow in surgical oncology at Evanston Hospital in Illinois.

James D Hogan, MD, LaCrosse, recently joined the medical staff of the Gundersen Clinic, Ltd. Doctor Hogan graduated from the Medical College of Wisconsin and completed his internship and pediatric residency at Milwaukee Children's Hospital. He also completed dermatology residencies at the Medical College of Wisconsin Affiliated Hospitals and the Marshfield Clinic.

Harry L Schwartz, MD,* Kenosha (left) and his nurse, Jan Mawacke, are shown holding an engraved Golden House Clock that he received from Abbott Laboratories. Abbott Laboratories presented the clock in commemoration of Doctor Schwartz's 50 years of outstanding service and dedication to medicine.

Dean E Whiteway, MD, LaCrosse, has become associated with the medical staff of the Gundersen Clinic, Ltd. Doctor Whiteway graduated from the University of Wisconsin Medical School, Madison, and completed his internship and residency at Gundersen Medical Foundation, Ltd. Prior to joining the Clinic in LaCrosse, he had been associated at Gundersen Clinic in Spring Grove, Minn.

Gregory L Darrow, MD,* Janesville, recently was cited for his entry in a national writing competition. Selected as first runner-up, Doctor Darrow's article entitled "But Doctor I Just Don't Understand," dealt with the improvement of patient-physician relationship through improved communications. The contest was open to journalists and physicians for original authorship of a significant medical essay contributing to the socio-economic betterment of medical practice.

William T Russell, MD,* Sun Prairie physician since 1949, recently announced his retirement from medical practice. Doctor Russell graduated from the University of Wisconsin Medical School in 1946 and served his internship at St Mary's Hospital in Madison. Active in the affairs of the State Medical Society of Wisconsin, Doctor Russell served and acted as chairman, of the Commission on Public Policy; was an alternate delegate to the American Medical Association from 1970-1975; served on the Commission on Scientific Medicine; Ad Hoc Committee to Review the Medical Practice Act; and past member and chairman of Reference Committee on Standing Committees of the House of Delegates. He also was a representative to a committee of the Wisconsin Nurses Association to review the Nurse Practice Act and was a member of the Committee on Physician Assistants. He was a preceptor at the University of Wisconsin Medical School and an assistant clinical professor of Family Practice. Doctor Russell is a member of the American Academy of Family Physicians and has served as president of the Dane County Chapter. The Sun Prairie Sertoma Club presented Doctor Russell with the "Service to Mankind" award in 1975.

Doctor Russell

James Bass Jr, MD,* Kenosha, has joined the medical staff of Kenosha Memorial Hospital. Doctor Bass graduated from the University of Michigan, Ann Arbor, in 1972, and completed his internship at Milwaukee County General Hospital. He served residencies at the University Hospital, Ann Arbor; University of Wisconsin Hospital, Madison; and Jewish Hospital in Cincinnati, Ohio. Certified by the American Board of Surgery, Doctor Bass also completed his thoracic and cardiovascular surgery residency at State University of New York in Buffalo.

Reganti V Reddy, MD,* Neillsville, recently was elected as president of the medical staff of the Neillsville Clinic. Other MDs elected as officers were Frederico P Gregario,* secretary; and Narasimhulu Neelagaru,* as treasurer.

John DeGiovanni, MD,* Prairie du Sac, recently was made a fellow of the American College of Surgeons at its annual meeting held in San Francisco. Doctor DeGiovanni is currently chief-of-staff at Sauk-Prairie Memorial Hospital and also is a member of the medical staff of Reedsburg Memorial Hospital and St Marys and Madison General Hospitals in Madison. ■

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**Meeting of Am Soc Colon/Rectal Surgeons, May 1980.*
***Based on total prescriptions filled for hemorrhoidal preparations during the first three quarters of 1981. The National Prescription Audit, IMS America Ltd, Sept 1981.*
†1981 data from leading marketing research organization.

PD-85-JA-0867-P-1 (2-82)

ANUSOL-HC® Suppositories/ ANUSOL-HC® Cream

Before prescribing, please see full prescribing information. A Brief Summary follows:

Indications and Usage: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain, itching and discomfort in external and internal hemorrhoids, proctitis, papillitis, cryptitis, and fissures, incomplete fistulas, pruritus ani and relief of local pain and discomfort following anorectal surgery.

Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol® Suppositories or Ointment.

CONTRAINDICATIONS

Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.

WARNINGS

The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.

PRECAUTIONS

General

Symptomatic relief should not delay definitive diagnoses or treatment.

Prolonged or excessive use of corticosteroids might pruduce systemic effects.

If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.

In the presence of an intection the use ot an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.

Anusol-HC is not for ophthalmic use.

Pregnancy

See "WARNINGS"

Pediatric Use

Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.

DOSAGE AND ADMINISTRATION

Anusol-HC Suppositories—Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at bedtime for 3 to 6 days or until inflammation subsides. Then maintain comfort with regular Anusol Suppositories.

Anusol-HC Cream—Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain comfort with regular Anusol Ointment.

NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.

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1089G010

Milwaukee Psychiatric Hospital, Wauwatosa, recently named Arthur Norris, MD* of Wauwatosa as its medical director. Doctor Norris, who has served as the hospital's clinical director for the past years, replaced Clifford Simske, MD.* Prior to joining the medical staff in 1979, Doctor Norris was clinical director of the Waukesha County Unified Community Services and also had been on the medical staff of the Milwaukee County Mental Health Center. He currently is president-elect of the Milwaukee Neuro-Psychiatric Society. He graduated from the University of Wisconsin Medical School in Madison.

St Clare Hospital, Monroe, recently named John Bailey as vice-president of professional services. Mr Bailey previously was associated with the McGuire Clinic in Richmond, Virginia, where he was executive director. A native of Madison, Wis, Mr Bailey obtained a master's degree in hospital administration from the University of Michigan. He is a member of the American College of Hospital Administration.

Marshfield Clinic recently reelected Nelson A Moffat, MD* as its president for a third successive annual term. Also elected to offices were MDs William J Maurer,* vice president; John P Milbauer,* secretary; and J Douglas Lee,* treasurer. Joining the officers on the new executive committee are MDs Cesar N Reyes;* Ben R Lawton;* William R Friedenberg;* Edward B Blau;* and James L Hoehn.* Doctor Moffat is the 13th physician to hold the top post since the Clinic's founding in 1916. He joined the Clinic in 1962, has been a Clinic director since 1965 and a member of its executive committee for most of those years. He also is a past chairman of the State Medical Examining Board.

St Vincent Hospital, Green Bay, has elected its executive committee for 1982. The MDs are Alan F Wentworth,* president; Joseph B Grace,* vice president; and Frederick J Lamont,* secretary. Other MDs elected as chiefs of departments are Orris S Keiser,* Family Medicine; James V Lacey,* Medicine; Edward G Vogel,* OB-GYN; Raymond A McCormick,* Pathology; Karen Camilli, Pediatrics; Ali Mohommed-Zadeh, Radiology; and Harold J Hoops Jr,* Surgery.

St Marys Hospital Medical Center, Madison, recently reelected Gerald J Derus, MD* to his second term as chief-of-staff. Other MDs reelected to serve with Doctor Derus were James W Rose, MD,* assistant chief, and Ronald D Wenger,* secetary-treasurer.

Memorial Community Hospital, Edgerton, recently elected the following physicians as its officers for the year 1982. They are MDs Suresh K Madan,* president and chief-of-staff; Craig S Ajdukovich,* vice president; and Michael F Hahn, secretary-treasurer. Doctor Madan specializes in internal medicine and is associated with the Shearer-Cohen Clinic. Doctor Ajdukovich also specializes in internal medicine and is associated with the Edgerton Clinic. Doctor Hahn, a pathologist, also is associated with the laboratory at Mercy Hospital in Janesville.

Milwaukee Academy of Medicine, at its 96th Annual Meeting, elected the following officers for 1982. They are MDs John P Mullooly,* president; Thomas J Russell,* president-elect; John R Litzow,* vice-president; Nicholas F Geimer, secretary; David J LaFond,* treasurer; Leonard Weistrop, librarian; and Anthony P Ziebert,* membership. MDs elected to serve on the Council are John H Esser;* Sharon L Elias;* Walter R Schwartz;* William L Lorton;* Jacob Lemann Jr;* and Archebald R Pequet,* Ex-Officio. The guest speaker at the meeting was Dr Edmund Pellegrino, president, The Catholic University of America, Washington, DC. Doctor Pellegrino spoke on "Ethics at the Bedside: The Need for a Compleat Morality."

American College of Physicians recently announced that Steven R Gambert, MD,* Bayside, and Patrick T Regan, MD,* Milwaukee, were elected to Fellowship in the Society. Doctor Gambert, a specialist in geriatrics/endocrinology, is a 1975 graduate of Columbia University College of Physicians and Surgeons and is on the staff of the Wood VA Medical Center, Milwaukee County Medical Center, and the Froedtert Memorial Hospital. Doctor Regan, a specialist in gastroenterology, is a 1972 graduate of Northwestern University Medical School, and is on the staff of Columbia and St Mary's hospitals in Milwaukee.

American College of Chest Physicians recently inducted into Fellowship of the Society the following Wisconsin physicians: MDs Mohammad A Cheema,* Milwaukee; Guillermo A doPico, Madison; and Kesavan C P Kutty, Milwaukee. The Convocation ceremonies took place at the ACCP's 47th Annual Scientific Assembly held in San Francisco, California.

East Madison and Dean Clinics merge. The 91 physicians of the East Madison and Dean Clinics in Madison merged their medical services January 1, 1982. According to Louis C Bernhardt, MD,* Madison, the merger has been in the planning stages for several years and represents an official organizational change which formalizes a consulting relationship that has existed for many years. William Rock, MD,* Madison, said there will be four clinic locations in Dane County: East Central, West, West-Madison and Sun Prairie.

The Jackson Clinic of Madison moved into its new building at 345 W Washington Avenue Monday, March 1. The new facility will accommodate 55 physicians and 250 other employees. All current medical services will be continued. Areas will be provided for four new services: immediate care, occupational health and medicine, cancer screening, and heart disease screening and prevention. The fifth floor of the Jackson Clinic will be the home of the Jackson Foundation for Medical Research and Education. ■

AMA Physician's Recognition Award Recipients

LISTED BELOW are those physicians in Wisconsin who have earned the AMA Physician's Recognition Award in recent months. The award was established in 1969 "to recognize, encourage and support physicians who participate regularly in continuing medical education and to emphasize the importance of developing more meaningful continuing medical education opportunities for physicians." A minimum of 150 credit hours of CME must be earned over a three-year period to qualify for the award. The hours may include such activities as conferences, residencies, teaching, writing, private reading, listening to cassettes, home study courses, consultation, and peer review; at least 60 of the hours, however, must be from formal CME programs sponsored or cosponsored by organizations accredited for these activities. The State Medical Society of Wisconsin congratulates the following physicians who have distinguished themselves and their profession by their commitment to continuing education:

JANUARY 1982

*Banaszak, Edward F, Milwaukee
*Bogost, Bruce R, Milwaukee
*Danforth, R Clarke, Milwaukee
*Dean, Warwick R, Marshfield
Dhanani, Shiraz P H, Madison
Hackney, Robert H, Ladysmith
*Haemmerle, James H, Menomonie
Hagen, Thad C, Wood
Hahn, Michael F, Janesville
Hale, Lanny B, Hales Corners
*Hammer, Roland M, River Falls
Hartigan, J Michael, LaCrosse
Hettler, Gerhard W, Stevens Point
Jones, Ethelene J, Milwaukee
*Kelley, William B, Milwaukee
Kochar, Arvind, Elkhorn
Magnino, James J, Kenosha
Miller, Pamela P, Milwaukee
*O'Connor, James J, Marshfield
*Pagels, George A, Marshfield
*Pavelsek, Joseph W, Portage
*Piper, Philip G, Janesville
Schaefer, Harry E, Manitowoc
*Scheibel, William R, Verona
*Spankus, Jack D, Milwaukee
Tristani, Felix E, Wood
*Troup, Richard H, Green Bay
*Vogt, Wess R, Mequon
*Wasserman, Anatolio, Marshfield
Weinman, Mary Sue, Madison
*Wilson, Janet A, Wisconsin Rapids
*Winston, Frank, Madison
*Wiviott, Wilbert, Milwaukee ■

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Phone ( ) _____
Medical School _____ Date Graduated _____
Medical Specialty _____ Date Passed ECFMG _____

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Obituaries

Joseph V Herzog, MD, 76, Sun City, Ariz, died Apr 24, 1981 in Sun City. Born Sept 16, 1904 in Cresco, Iowa, Doctor Herzog graduated from Marquette University School of Medicine in 1930 and served his internship at Deaconess Hospital in Milwaukee. Doctor Herzog had practiced medicine in Milwaukee until his retirement in 1970. He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and the American Medical Association. Surviving are his widow Pauline; and three children, William, James, and Thomas.

Sam Salan, MD, 83, Waupaca, died Dec 9, 1981 in Waupaca. Born May 5, 1898 in Russia, Doctor Salan graduated from the University of Indiana Medical School in 1923 and served his internship at Fort Wayne's Methodist Hospital. He practiced medicine in Waupaca for 56 years and also served as county coroner for 18 years. He served on the medical staff of St Michael's Hospital, Stevens Point, and St Elizabeth's Hospital in Appleton. He also was on the medical staff of Riverside Community Memorial Hospital in Waupaca. Doctor Salan served in the United States Army during World War I. He was a member of the "50 Year Club" of the State Medical Society of Wisconsin, member of the Waupaca County Medical Society, and the American Medical Association. Surviving are his widow, Isabel; and two sons, David W, and Dr Jerry, of Waupaca.

David L Williams, MD, 76, Madison, died Dec 19, 1981 in Madison. Born Sept 3, 1905 in Madison, Doctor Williams graduated from the University of Wisconsin Medical School, Madison, in 1930 and served his internship and residency at the Methodist Hospital in Madison. He was in private practice from 1933 until 1960 when he became a member of the medical staff of the Jackson Clinic in Madison. Active in the Red Cross for many years, Doctor Williams took an active part in introducing First Aid training into the Madison and Dane County Police and Fire departments. He also served as team physician for West High School, Madison, for many years. He was a member of the American College of Obstetricians and Gynecologists, the Dane County Medical Society, State Medical Society of Wisconsin, and the American Medical Association. Surviving are his widow, Leta; two sons, Frederic, Madison, and Reginald of San Antonio, Texas.

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Joseph F Kovacic, MD, 72, Naples, Fla, died Dec 22, 1981 in Naples. Born Oct 10, 1909 in Sheboygan, Doctor Kovacic graduated from the Marquette School of Medicine, Milwaukee, in 1936 and served his internship at St Joseph Hospital in Milwaukee. He began his medical practice in Sheboygan in 1940 and practiced there until his retirement in 1977. He was past president of the Sheboygan County Medical Society and was an originator and collector of the history of the Sheboygan County Medical Society. He also was a member of the State Medical Society of Wisconsin and the American Medical Association. Surviving are his widow; Mary Jean; a son, Jerald J, New York, and a daughter, Mrs F E (Barbara) McCoy of St Petersburg, Fla.

William R McInnis, MD, 57, Marion, died Jan 6, 1982 in Clintonville. Born Jan 24, 1924 in Eau Claire, Doctor McInnis graduated from the Marquette School of Medicine in 1950 and served his internship at Milwaukee County General Hospital. He was a member of the American Academy of Family Physicians and the Fox Valley Academy of Medicine. He had served as chief-of-staff of the Clintonville Community Hospital. Surviving are his widow, Mary; four daughters, Kathleen and Margaret, Milwaukee, Maureen, LaCrosse, and Aileen of Fairbanks, Alaska; eight sons, Dr Michael, Rock Springs, Wy; Patrick, Jackson, Wy; Timm, Green Bay; William, Fairbanks, Alaska; Thomas, Brian, Cormac, and Christopher all at home.

Alfred N E Merten, MD, 86, Milwaukee, died Jan 16, 1982 in Milwaukee. Born July 16, 1895 in West Bend, Wis, Doctor Merten graduated from Marquette University School of Medicine in 1918 and served his internship at Milwaukee Hospital. He served in the United States Navy during World War II. He was a member of the Milwaukee Academy of Medicine and the American Society of Geriatrics. He also was a member of the "50 Year Club" of the State Medical Society of Wisconsin, the Medical Society of Milwaukee County, and the American Medical Association. Surviving are his widow, Marie; a son, Walter of Neosho and a daughter, Florence Fridl of Elm Grove.

Clifford M Creswell, MD, 75, Kenosha, died Jan 18, 1982 in Kenosha. Born Oct 26 1906 in Wellman, Iowa, Doctor Creswell graduated from the University of Iowa Medical School in 1932 and served his internship at Rochester General Hospital, Rochester, NY. He served in the United States Navy from 1943 to 1946. Doctor Creswell had been associated with the medical staff of the Kenosha and St Catherine's hospitals, and had practiced in Kenosha from 1937 until his retirement in 1980. ■

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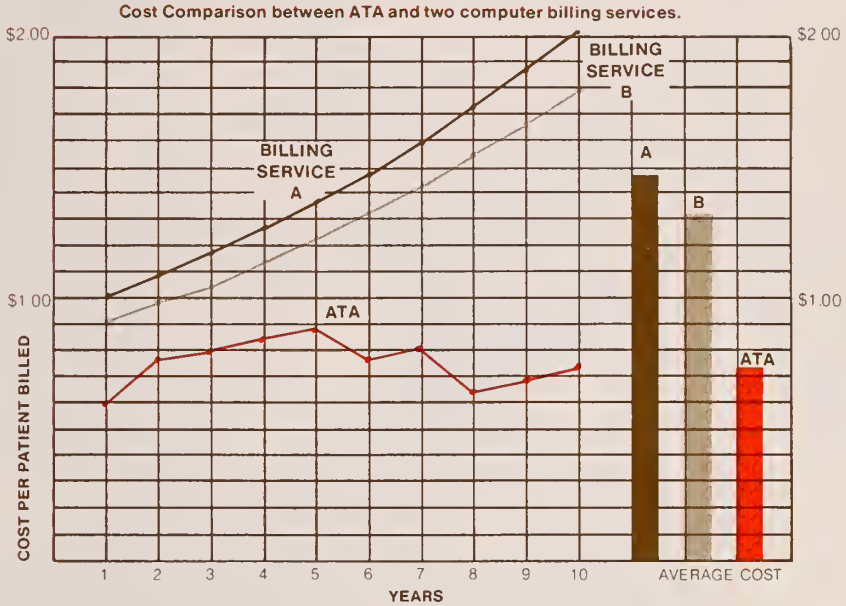

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INDICATIONS: *Therapeutically* (as an adjunct to systemic therapy when indicated), for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection. *Prophylactically*, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: Not for use in the eyes or in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

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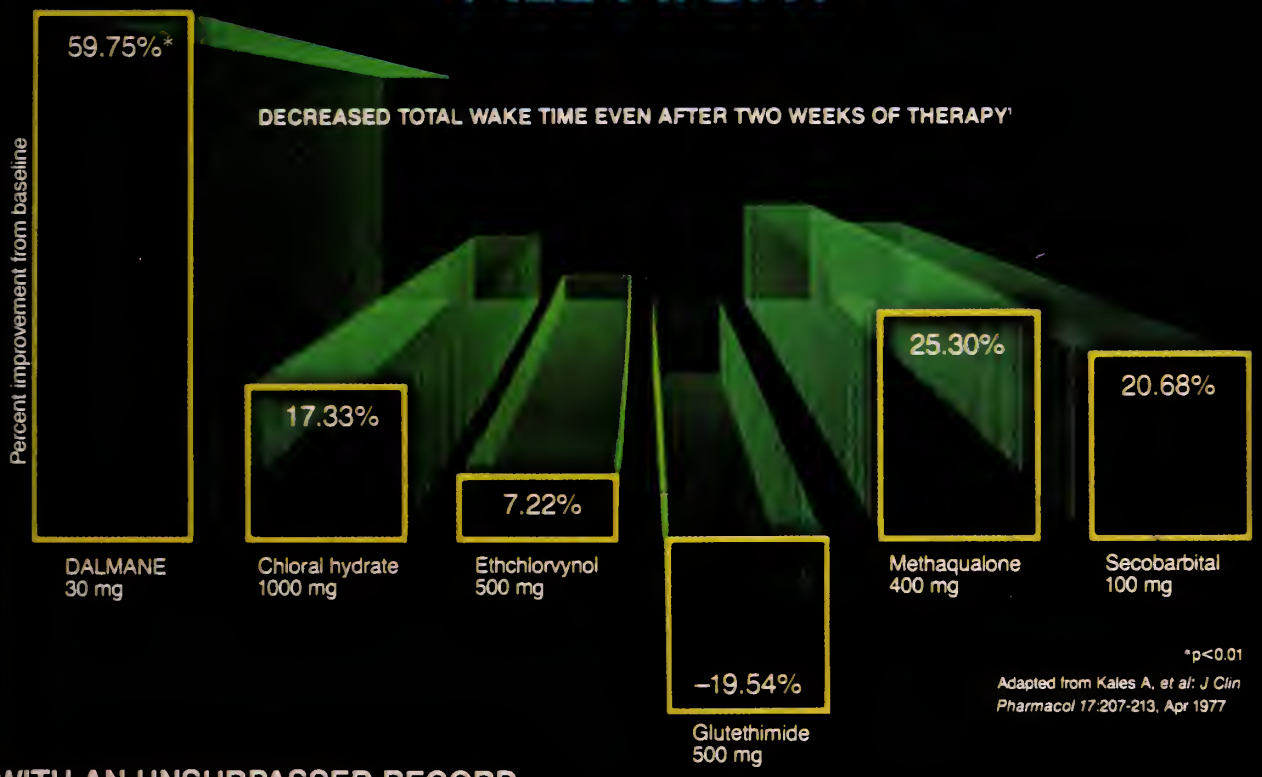

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–which can require careful monitoring in cardiovascular patients[10]

–which have strong anticholinergic effects[10]

Antihistamines

–which are *not* reliable sleep-inducing agents[11]

–which may produce stimulation instead[11]

–which have anticholinergic effects[11]

Major tranquilizers

–whose side effects may be troublesome for nonpsychotic patients[12]

–where tolerance for sedation appears rapidly[12]

Dalmane does not cause significant worsening of sleep beyond baseline levels upon discontinuation.[4]

References: **1.** Kales A, *et al*: *J Clin Pharmacol* 17 207-213, Apr 1977 **2.** Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ **3.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther* 21 355-361, Mar 1977 **4.** Kales A, *et al*: *Clin Pharmacol Ther* 18 356-363, Sep 1975 **5.** Moore JD, Weissman L: *J Clin Pharmacol* 16 241-244, May-Jun 1976 **6.** Spiegel HE: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ **7.** Robinson DS, Amidon EL: Interaction of benzodiazepines with warfarin in man, in *The Benzodiazepines*, edited by Garattini S, Mussini E, Randall LO. New York, Raven Press, 1973, pp 641-646 **8.** Warfarin Study: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ **9.** Baldessarini RJ: Drugs and the treatment of psychiatric disorders, chap 19, in Goodman and Gilman's *The Pharmacological Basis of Therapeutics*, ed 6. New York, Macmillan Publishing Co Inc., 1980, pp 391-447 **10.** Cole JO, Davis JM: Antidepressant drugs, chap 31.2, in *Comprehensive Textbook of Psychiatry II*, edited by Freedman AM, Kaplan HI, Sadock BJ, ed 2. Baltimore, The Williams & Wilkins Company, vol 2, 1976, pp 1941-1956 **11.** Douglas WW: Histamine and 5-hydroxytryptamine (serotonin) and their antagonists, chap 26, in Goodman and Gilman's *The Pharmacological Basis of Therapeutics*, ed 6. New York, Macmillan Publishing Co Inc., 1980, pp 609-646 **12.** Davis JM, Cole JO: Antipsychotic drugs, chap 31.1, in *Comprehensive Textbook of Psychiatry II*, edited by Freedman AM, Kaplan HI, Sadock BJ, ed 2. Baltimore, The Williams & Wilkins Company, vol 2, 1976, pp 1921-1940

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect.
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Physicians Exchange

Wausau Medical Center, SC, a 50-physician multispecialty group has openings for physicians in the following specialties: *Family Practice, Neurology, Otolaryngology,* and *General Surgery* with a fellowship training in *Peripheral Vascular Surgery.* Competitive first-year salary, incentive plan thereafter. Comprehensive fringe benefits. New facility near new hospital. Located in beautiful, quiet, central Wisconsin, metropolitan area of 65,000. Recreational opportunities abundant. For more information contact: K L Day, MD, Wausau Medical Center, SC, 2727 Plaza Drive, Wausau, Wis 54401, or call collect 715/847-3351. 3tfn/82

The Nicolet Clinic, SC, a young progressive 38-physician multispecialty group, has superb opportunities available for the practice of *General Surgery, Neurology,* and *Radiology.* Ideal family oriented community in metropolitan area with excellent schools, economy, culture and recreation for all four seasons. Located on northern Lake Winnebago. First year negotiable salary with option for full membership at nine months. Adjacent to modern regional hospital. Excellent benefits in addition to qualified profit-sharing plan and support for continued education. Contact in confidence: Curtis C Baltz, MD, Nicolet Clinic, SC, 411 Lincoln St, Neenah, Wis 54956; ph 414/727-4244. 3-6/82

The Department of Family Practice, The Medical College of Wisconsin, is recuiting for a full-time faculty position of a 12-resident Family Practice program. Practice experience and Board certification required. City of 50,000, Southeastern Wisconsin, excellent schools, 20 miles from Milwaukee, superior living. Faculty rank and salary are negotiable, dependent upon qualifications and experience. Many fringe benefits. Send curriculum vitae and references to: Director, Waukesha Family Practice Residency Training Program, 434 Madison St, Waukesha, Wis 53186. The Medical College of Wisconsin is an Equal Opportunity/Affirmative Action Employer. 3/82

Green Bay, Wisconsin. Well established fee-for-service group in regional trauma/poison center seeks additional physician. 35,000 plus annual visits. Competitive salary with paid liability, CME, pension/profit sharing. Excellent recreational and educational opportunities. Great place to raise a family. Send CV to: A W Haines, MD, 435 Shady Drive, Oneida, WI 54155; ph 414/865-7740. 1tfn/82

PRIMARY CARE PHYSICIANS
BOARD CERTIFIED OR ELIGIBLE

We represent over 50 communities throughout the state which are seeking quality primary care physicians. These communities offer established service areas, generous practice and financial arrangements.

CONTACT:
Laurie Glowac or Fred Moskol
New Physicians for Wisconsin
University of Wisconsin Department of Family Medicine
777 South Mills Street, Madison, Wisconsin 53715
Phone: 608/263-4095

1-12/82

General and Vascular Surgeon. Board eligible/certified to join 9-man multispecialty group in Southeastern Wisconsin. Well established, recreational setting. Adjacent to 150-bed hospital. Send CV to Administrator, Burlington Medical Center, 190 Gardner Ave, Burlington, Wis 53105. p3-5/82

Internist wanted. Board certified or eligible with/without subspecialty, to practice in conjunction with a 6-member Internal Medicine Department in a 22-member multispecialty group. Present subspecialties: Gastroenterology and cardiology. The group is in Southeastern Wisconsin, in a city of 100,000 between two major metropolitan areas of greater than one million. If interested, please send CV to: Stephen L Wagner, Kurten Medical Group, 2405 Northwestern Ave, Racine, Wis 53404. All inquiries will be kept confidential. 3tfn/82

Immediate opportunities for emergency medicine physicians who possess excellent clinical and communication skills to join longstanding group of Emergency Physicians. Positions available in a popular Wisconsin area bordering Illinois. If interested, send resumé to Barbara Wilcynski, Medical Emergency Service Associates (MESA), SC, 15 S McHenry Road, Suite 2, Buffalo Grove, Ill 60090; or call collect 312/459-7590. 3-4/82

OB/GYN Specialists. Enjoy the security of group practice with the freedom of independent practice. If you are Board Certified or Board Eligible in OB/GYN, we have an interesting opportunity for you. Two specialists are needed immediately to form an independent OB/GYN practice in a very desirable Northern Wisconsin community with a drawing population of 70,000. Active practice assured. All major specialists available for consultation. Business and technical advice will be provided. Outstanding personal benefit programs available. Good income potential. New 35 million dollar hospital. For further information write: Administrator, PO Box 1646, Wausau, Wisconsin 54401. 2-4/82

Two Family Practice Physicians sought to assume a fully operational practice in a community 30 miles north of Madison, Wisconsin. New clinic facility. Income guaranteed. Physician back-up available. Board certified or eligible preferred. Contact John P Rahm, MD, 6105 Ridgewood Ave, Madison, Wis 53716. 5tfn/81

General and vascular surgeon, FACS, Board certified, highly qualified, with several years of practice, would like to join an individual or group with an established practice in metropolitan Milwaukee area. Contact Dept 493 in care of the Journal. 3tfn/82

Surgeon with Thoracic general vascular training and Ophthalmologist to join a progressive multispecialty group of 17 physicians consisting of General/Family Medicine, General Surgery, Internal Medicine, OB-GYN, Ophthalmology, Orthopaedic Surgeon, Pediatrics/Adolescent Medicine, and Radiology. Subspecialties include: Pathology, Vascular Surgery, Cardiovascular Diseases, Gastroenterology and Endoscopy. We are located in a fast growing, scenic, lake country area between Milwaukee and Madison and can offer excellent hospital, schools and recreational facilities. Full fringe benefit package. Contact: James F Dowd, Admin, Wilkinson Clinic, SC, 915 East Summit Ave, Oconomowoc, Wis 53066; ph 414/567-4433. 9tfn/81

Physicians Exchange

continued

Physician wanted to perform light physicals on a full or part-time basis. Ideal job for retiring physician. Contact Mike Stough collect at 513/621-8728. 10 tfn/81

The Racine Medical Clinic, a progressive cluster corporation of 25 physicians, is currently seeking an orthopedic surgeon and an invasive cardiologist. Full benefits, unlimited earnings and a full and exciting practice are offered. Please contact: Roger D Lacock, Administrator, Racine Medical Clinic, 5625 Washington Ave, Racine, WI 53406; ph 414/886-5000. 1tfn/82

Family physician, Board Certified or Eligible, to join four-man family practice group in northwest Wisconsin. First-year guaranteed salary. New clinic building located adjacent to 46-bed hospital, in the heart of Wisconsin's vacationland. Call shared with other family practice physicians in area, weekend coverage contracted. Jeanne Chamberlain, Adm, Spooner Clinic Ltd, 707 Ash St, Spooner, Wis 54801. Ph 715/635-2151. 12/81; 1-5/82

Pediatric, Family Practice positions available in 13-member multispecialty group. Inquire: General Clinic of West Bend, Inc, 279 S 17th Ave, West Bend, Wis 53095. 2tfn/82

University Health Service: Gynecologist or generalist for women's health program, willing to work in team approach. Routine gynecological care, family planning services, health education, supervising nurse practitioners. Board-certification preferred. Illinois license or eligibility for license by time of appointment. Campus of 25,000, 1-1/2 hours from downtown Chicago. Position available immediately. For further information and application contact Director, University Health Service, Northern Illinois University, DeKalb, Ill 60115; ph 815/753-1311. Equal opportunity/Affirmative Action employer. 2-3/82

Wanted. Board certified or eligible orthopedic surgeon to practice in conjunction with a 5-member surgery department in a 22-member multispecialty group. Present surgical specialties: thoracic and vascular surgery, general surgery and urology. The group is located in the upper midwest, in a city of 100,000 between two major metropolitan areas of greater than one million. If interested, please send CV to: Stephen Wagner, Kurten Medical Group, SC, 2405 Northwestern Ave, Racine, Wis 53404. All inquiries will be kept confidential. 12tfn/80

General Surgeon. Board eligible/certified to join primary care group of six family physicians. Well established, rural setting, preceptor University of Wisconsin, JCAH 70-bed hospital. Send CV to: Gary Petersen, MD, Krohn Clinic, Ltd, 610 W Adams St, Black River Falls, Wis 54615. 10 tfn/81

Dermatologist, Rheumatologist needed to join multispecialty group of 33 physicians dedicated to primary care in East Central Wisconsin community. City population 48,000, drawing area 100,000. Attractive income arrangements, association membership possible after one year, pension and profit sharing, extensive fringe benefits. Contact: R B Windsor, MD, 1011 North 8th St, Sheboygan, Wis 53081; ph 414/457-4461. 12tfn/81

PUT EXPERIENCE TO WORK FOR YOU WHILE YOU SEARCH FOR A NEW CHALLENGE

Let years of experience as a healthcare professional and a Placement Counselor assist you in finding a new location with a new challenge. Physicians in all specialties are urgently needed throughout the country. Many types of situations available. Confidentiality assured.

Contact Donna Herschleb, RN
MEDICAL PROFESSIONAL PLACEMENTS
5222 Painted Post Drive, Madison, Wisconsin 53716
Phone: (608) 222-2927 *Licensed Employment Agency*

Faculty Member Family Practice Program. The Black Hawk Area Medical Education Foundation is recruiting a Board Certified Family Physician to join its Family Practice Residency Program in Waterloo, Iowa. The program is community-based, affiliated with the University of Iowa College of Medicine, and part of the Iowa Network of Family Practice Residency Programs. The Waterloo metropolitan area has 125,000 people, four hospitals, and is well represented in the medical specialties. Applicants should have a MD degree, be eligible for licensure in Iowa, and should have several years of practice experience. Major duties include teaching residents in all aspects of patient care, including obstetrics, and also providing patient care. Other duties include some program administration and assisting in research from time to time. A salary in the range of $60,000 per year with an additional 20% fringe benefit package is offered. Other fringe benefits relating to retirement, moving expenses, and continuing education are provided. Please submit your resume to: Charles A Waterbury, MD, Program Director, Black Hawk Area Medical Education Foundation, 441 East San Marnan Dr, Waterloo, Iowa 50702; ph (319) 234-4419. Equal Opportunity Employer. 1-4/82

Immediate opening for General and Child Psychiatrist to join well-established clinic in a community of 50,000. Large referral area. Two excellent hospitals. University and industrial area. Salary open. Excellent benefits. Contact: J M Tobin, MD, Northwest Psychiatric Clinic, Box 224, Eau Claire, Wis 54701; ph 715/834-2751. 12/81; 1-3/82

Family Practice and Urology positions available with an 18-member multispecialty group corporate practice. Modern clinic facility in Northeastern Wisconsin city of 100,000 enjoying a healthy and stable economy. Excellent recreational, educational, hospital, civic advantages. Please call collect or write: W J Mommaerts, Clinic Manager, West Side Clinic, SC, 1551 Dousman St, Green Bay, WI 54303; ph 414/494-5611. 1-4/82

Fifty-physician, multi-specialty clinic in west central Wisconsin wants neonatologist, neurologist, neurosurgeon, orthopedic surgeon, and otolaryngologist. Excellent cultural, educational, and recreational facilities. 90 miles from Minneapolis. Please contact James R Jepson, Administrator, Midelfort Clinic, Ltd, 733 West Clairemont Ave, Eau Claire, Wis 54702; or call 715/839-5266. 2-4/82

Anesthesiologist, Board certified, to join a 250-bed community hospital in southeastern Wisconsin as its Director of Anesthesiology. Send curriculum vitae to Dept 498 in care of the Journal. 2-3/82

Physician wanted to share fully equipped medical office, x-ray, lab, fully staffed, small community, northern Wisconsin. Contact Dept 496 in care of the Journal. 12/81; 1-4/82

Multispecialty group (13) Door County Wisconsin needs to replace retiring OB-GYN and General Surgeon. Write Door County Medical Center, PO Box 447, Sturgeon Bay, Wis 54235 or call John D Turk, Admin, at 414/743-7261. 2-4/82

Medical Facilities

Port Washington, Wisconsin. New prime office space in professional building. Upper level already occupied by three internists (specializing in cardiology), one dentist, and three doctors of chiropractic. Lower level has 700-2500 sq ft. Area needs obstetrician-gynecologist, pediatricians, urologist, dermatologist, and general practitioner. X-ray machines and equipment possible. Twenty miles north of Milwaukee. Phone 414/375-3010 or 414/284-0500 or write 1032 S Spring St, Port Washington, Wis 53074. 2-3/82

For Sale. diagnostic equipment including standard x-ray, Clay Adams blood chemistry analyzer, Accustat blood cell counter, centrifuge, Lumiscribe portable minigraph EKG, examining tables and cabinets, office furniture and equipment and other miscellaneous. Contact Dept 499 in care of the Journal or call 414/965-2600 after 8:00 AM. 3-5/82

Medical office space for lease. New Swiss chalet style building in fast growing community. Needs family practitioner, pediatrician, etc. Building has dentist and pharmacy. Very reasonably priced in Waukesha County near expressway. Info: call 414/781-1155. 3tfn/82

Milwaukee. Busy family medical center for sale. Will introduce. Good for teaching interns and residents in Family Practice. Contact: R Gonzalez, MD; ph 414/344-1120 or 414/476-8624. 3-8/82

Office Space For Rent. Three examining rooms, one x-ray room, and waiting room in medical clinic in a town of 3000. This clinic formerly provided a very strong practice for two family practitioners for 15 years. The village of Sturtevant is located three miles from a new major medical center. Just south of Milwaukee and near Lake Michigan where fishing and sailing is just minutes away. Also, inland lake living is within seven miles of here. One or two physicians interested in a long term commitment will find the lease terms to be *very* reasonable and land is available to add on to or to remodel the present clinic area. Contact Ronald E Schroeder, 8700 Racine Ave, Sturtevant, Wis 53177; ph 414/886-4178. 2-4/82

Immediate solo practice available in Jefferson, Wisconsin, due to the recent death of Richard H Siedenburg, MD. Expandable building with three large lots available. Lease or purchase. Contact Miller Law Office, PO Box 417, Jefferson, Wisconsin 53549; ph 414/674-3345. g11tfn/81

Prime east Madison medical office space to share. 2000 sq ft. Fully equipped and well furnished. Private office and sound proof examining rooms. X-ray, lab, and physical therapy facility on premises. Equipped minor surgery room. Share rent and staff expenses on a 50-50 basis or prorated to your needs. For more information and appointment to view facility, call C A Gencheff, DO: 608/241-3451. 12/81-1/82*

Medical office available. Prime Shorewood location. Excellent opportunity for MD to buy into Milwaukee suburban medical building. Office, two examination rooms, use of reception area, waiting room, and lab. Available immediately. Phone 414/963-9020. 3/82

Real Estate

A SAFE TAX SHELTER. Land ownership offers more. The new A.C.R.S. (Accelerated Cost Recovery System). Depreciation + Inflationary Appreciation + Investment Credits, all put money into your pocket. FAITH REALTY—Est 1960, Farm Specialist-Tax Consultant, Whitewater, Wis 53190 (414/473-2779). PS: Who do you know who wants to buy a farm? p3-8/82

CONSULTANT FOR FLORIDA REAL ESTATE

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Miscellaneous

Author's editor. Technical assistance for your manuscripts and medical writing. K M Lopate, Picas Anon, 235 N Eastmoor, Brookfield, Wis 53005; ph 414/786-3922. 1tfn/82

Publications

Discussion of FDA Priorities, Fiscal Year 1983 Planning Process, May 1981. Booklet prepared by the Office of Planning and Evaluation, Department of Health and Human Services. Development of FDA program priorities is a key part of the Agency's annual planning and budgeting process. The opinions which are gathered from health professionals and other participants are used by the Commissioner and top Agency managers during their discussion of future program priorities. This booklet summarizes the votes from 144 health professionals. It also contains the votes of 294 other participants representing consumers, state officials, trade associations, FDA field, and FDA staff executives. In addition it presents some reasons and values behind the votes. Request for copies may be directed to: John C Duffy, MD, Deputy Associate Commissioner for Health Affairs (Professional Relations), Department of Health and Human Services, Public Health Service, Food and Drug Administration, Rockville, Md 20857.

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Meetings/CME Courses

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates: 40¢ per word, with a minimum charge of $16.00 per listing. BOXED LISTINGS: $32.00 per column inch. COPY DEADLINE for Continuing Medical Education listings is tenth of the month preceding the month of publication; e.g., copy for the August issue is due by July 10. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 800/362-9080. For listing of other meetings see the Special issue of the Journal of the American Medical Association: Continuing Education Courses for Physicians for period Sept 1, 1981 through Aug 31, 1982.

WISCONSIN

APRIL 2-3, 1982: *Advances in Emergency and Cardiovascular Critical Care,* Sheraton Inn, Madison. Sponsored by the Methodist Hospital and the Jackson Clinic. Info: Mark Olsky, MD, Director, Emergency Services, Methodist Hospital, 309 W Washington Ave, Madison, Wis 53703; ph 608/251-2371.

APRIL 14-16, 1982: Third Annual Madison Clinic Conference, *Therapeutic Management of Cardiovascular Diseases.* Sponsored by Extension Services in Pharmacy and the School of Pharmacy, University of Wisconsin, Madison. Info: Alan L Hanson, PhD, Extension Services in Pharmacy, School of Pharmacy, 425 N Charter St, Madison, Wis 53706; ph 608/262-3130.

APRIL 14, 1982: *Evaluation and Management of Pain in the Elderly,* Wood VA Medical Center, Wood Auditorium. Sponsored by Section of Geriatrics & Gerontology, Wood VA Medical Center and The Medical College of Wisconsin. Category I credits available: 6 AAFP and Nursing credits applied for. Info: Steven R Gambert, MD, Chief, Geriatrics Section/111P Wood VA Medical Center, 5000 West National Avenue, Wood, Wis 53193. (See further details elsewhere in this section.)

APRIL 16-17, 1982: *Second Annual General Surgery Conference: Breast and Endocrine Disease,* University of Wisconsin Clinical Science Center, Madison. Sponsored by University of Wisconsin Dept of Surgery, University of Wisconsin-Extension Dept of Continuing Medical Education. Approved 9 credit hours AMA Category I, UW Extension CEUs. Fee: $155 physicians; $100 residents, nurses, others. Info: Sarah Z Aslakson, Continuing Medical Education, 465B WARF Bldg, 610 Walnut St, Madison, WI 53706; ph 608/263-2856.

APRIL 19-23, 1982: *Cardiac Rehabilitation Workshop,* La Crosse. See details elsewhere in this section.

APRIL 20, 1982: Milwaukee Academy of Medicine program—*Clinimetrics: An Additional Basic Science for Clinical Medicine,* AOA Lecture, by Alvan Feinstein, MD, Professor of Medicine and Epidemiology, Yale University, New Haven, CT. Info: Milwaukee Academy of Medicine, PO Box 26509, 8701 Watertown Plank Road, Milwaukee, WI 53226 (phone 414/257-8249).

APRIL 27, 1982: Milwaukee Ophthalmological Society, University Club, 924 E Wells St, Milwaukee, Wis 53202. Speaker: Dr J A McCrary, Baylor College of Medicine. Dinner at 6:30 pm and meeting at 7:30 pm. Info: John Ridley MD, 2315 N Lake Dr, Seton Tower, #1001, Milwaukee, Wis 53211; ph 414/278-7500.

APRIL 28-30, 1982: *State of the Art-Radiologic Approaches to the Chest and Abdomen,* Madison. Sponsored by the University of Wisconsin-Extension; Dept of Continuing Medical Education; and University of Wisconsin, School of Medicine, Dept of Surgery. Approved 21 credit hours of Category I AMA and ACR. Info: Sarah Z Aslakson, Continuing Medical Education, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

STATE MEDICAL SOCIETY OF WISCONSIN
Dates and Locations of Annual Meetings
1982-1992

All meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) and the new Hyatt Regency as the headquarters hotel with the exception of 1985, when the meeting will be held at the LaCrosse Convention Center.

1982—May 13-15	**1987—Mar 26-28**
1983—Mar 24-26	**1988—Apr 28-30**
1984—Mar 29-31	**1989—Apr 13-15**
1985—Apr 25-27	**1990—Apr 26-28**
1986—Apr 17-19	**1991—Apr 18-20**
	1992—Apr 23-25

Meeting days will be Thursday and Friday; the first session of the House of Delegates will convene on Thursday, the second and third on Friday. Scientific programming will be on Friday and Saturday.

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701. Local telephone: 257-6781; toll-free in Wisconsin: 1-800/362-9080.

DYING WITH ONE'S RIGHTS ON?:
THE MENTAL HEALTH COMMITMENT LAWS

Thursday, June 10, 1982
Pfister Hotel, Milwaukee

A forum presented by the Department of Psychiatry, Mount Sinai Medical Center; and co-sponsored by: The Milwaukee Bar Association, Milwaukee Psychiatric Hospital, and The Wisconsin Psychiatric Association

The Presenters: *Jules Coleman, PhD,* Tucson, Ariz; *David Saicheck,* Milwaukee; *Alan A Stone, MD,* Cambridge, Mass; *Thomas Szasz, MD,* Syracuse, NY; *Darold A Treffert, MD,* Fond du Lac; *Mona Wassow, MSW,* Madison; and *Thomas Zander,* Milwaukee

Registration: $55. Info: Ms Sue Reichard, Mount Sinai Medical Center, 950 N 12th St, PO Box 342, Milwaukee, Wis 53201; ph 414/289-8026.

APRIL 30-MAY 1, 1982: Wisconsin Urological Society, Concourse Hotel, Madison.

MAY 5-7, 1982: *Fifth Annual Cardiac Rehabilitation Symposium,* Red Carpet Inn, Milwaukee. Sponsored by Mt Sinai Medical Center, Milwaukee; University of Wisconsin-Extension, Dept of Continuing Medical Education; American Heart Association, and American College of Sports Medicine. Approved 25 credit hours of Category I AMA; AOA Category 2-D, University of Wisconsin Continuing Education Units. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

MAY 6-7, 1982: *Trends in Radiologic Technology—1982,* Wisconsin Center, Madison. Sponsored by Allied Health Program Unit, UW-Extension; Dept of Radiology, School of Medicine, University of Wisconsin. ECE points applied for from ASRT, University of Wisconsin Continuing Education Units. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, WI 53706; ph 608/263-2856.

MAY 13-14, 1982: *8th National Conference on Case Resolution of Complex Industrially Injured,* Pioneer Inn, Oshkosh. Sponsored by Industrial Injury Clinic, University of Wisconsin-Extension, Continuing Medical Education, in cooperation with Theda Clark Regional Medical Center. AMA Category I, Continuing Legal Education credits, Commission on Rehabilitation Counselor Certification, University of Wisconsin Continuing Education units. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, WI 53706; ph 608/263-2856.

MAY 23-25, 1982: Wisconsin Chapter, American Academy of Pediatrics, Playboy Club, Lake Geneva.

JUNE 4-5, 1982: *Diabetes Mellitus—1982,* Madison. Sponsored by University of Wisconsin School of Medicine, Department of Medicine; and University of Wisconsin-Extension, Continuing Medical Education. AMA Category 1, AOA Category 2-D, AAFP, University of Wisconsin Extension Continuing Education Units. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

JUNE 6-10, 1982: *Managing Health Care Resources in the Competitive Environment of the 1980s,* La Crosse. Sponsored by Western Wisconsin Health Systems Agency, University of Wisconsin Extension, and the University of Wisconsin La Crosse Business Outreach Department. Guest speakers include, Dr Alain Enthoven, Stanford University; Dr Erik Ritman, Mayo Medical School; and Dr Larry Cummings, Northwestern University. Info: Thomas M Lynch, Conference Director, Western Wisconsin Health Systems Agency, 1707 Main, La Crosse, WI 54601; ph 608/785-9352.

SPRING CANCER CONFERENCE

May 20, 1982, Valley Inn
Neenah, Wisconsin

This conference is sponsored by the Wisconsin Clinical Cancer Center for physicians and nurses in Fox River Valley and surrounding area.

Topics of this one-day course include high risk populations, breast cancer options, management of colon and lung cancers, the hospice concept in Wisconsin, and coping with cancer chemotherapy.

Approved 5 credit hours Category 1 CME.

Fee: $25.00

Info: Wisconsin Clinical Cancer Center, 1300 University Ave, 7C, Madison, Wis 53706. Contact Paul C Tracy, MD, 608/263-3455 or Sharon J Olsen, RN, 608/262-1357. 3/82

EVALUATION AND MANAGEMENT OF PAIN IN THE ELDERLY

Wednesday, April 14, 1982
Wood VA Medical Center,
Wood Auditorium, Wood, Wisconsin

Sponsored by Section of Geriatrics and Gerontology, Wood VA Medical Center and The Medical College of Wisconsin

This program is aimed at physicians and nurses who care for the elderly in a variety of settings. Upon completion of this program the participants will be able to describe the physiological changes that effect the pharmacokinetics of drugs when taken by an elderly individual; describe the pain assessment process; discuss drug misuse as it applied to the elderly person; identify alternative approaches to the management of pain in the elderly.

Participants and Program: *Welcome Remarks,* Mr Leon Edman and Mahendra Kochar, MD; *Introduction and Overview of Pain in the Elderly,* Steven R Gambert, MD; *Clinical Pharmacology of Pain Medications,* John S Holcenberg, MD; *Rheumatic Disease, Pain, and the Elderly,* Robert Wortman, MD; *Approach to Pain Control in the Terminally Ill Elderly Patient,* Sheldon L Burchman, MD; *Terminal Illness and Pain Management,* Edmund H Duthie Jr, MD; Tom Anderson, MD; Sheldon L Burchman, MD; Paul E Hankwitz, MD; John S Holcenberg, MD; *Nursing Approaches to the Management of Pain in the Elderly,* Sheila Curtis, RN; *Nursing Approaches to the Management of Pain in the Elderly,* Ruth Wiesbrook, RN; Sheila Curtis, RN; Sherri Bauer, RN; Irene Schreck, RN; Diane Stater, RN; *Current and Future Alternatives for Pain Control,* Thomas Beresford, MD

Category I credits available: 6 AAFP and Nursing credits applied for.

Info: Steven R Gambert, MD, FACP, Program Chairman, Chief Geriatrics Section/111P, Wood VA Medical Center, 5000 West National Ave, Wood, Wis 53193.

CANCER PAIN MANAGEMENT CONFERENCE

May 6-7, 1982, Concourse Hotel
Madison, Wisconsin

This conference is sponsored by the Wisconsin Clinical Cancer Center, University of Wisconsin-Madison.

The programs present an overview of cancer pain as well as problems, progress, assessment, and approaches to pain management.

Four workshops are also included (attendees may choose two): psychological aspects of pain, analgesics, neuroablative procedures and rehabilitation, and the role of palliative cancer therapy.

Approved 10 credit hours Category I AMA, CME/PRA.

Fee: Physicians $150; non-physicians $75.

Info: Wisconsin Clinical Cancer Center, 1300 University Ave, 7C, Madison, Wis 53706. Contact Paul C Tracy, MD, 608/263-3455 or Sharon J Olsen, RN, 608/262-1357. 3/82

JUNE 7-11, 1982: *Cardiac Rehabilitation Workshop,* La Crosse. See details elsewhere in this section.

JUNE 10, 1982: *Dying With One's Rights On? The Mental Health Commitment Laws,* Pfister Hotel, Milwaukee. Sponsored by Department of Psychiatry, Mount Sinai Medical Center and co-sponsored by The Milwaukee Bar Association, Milwaukee Psychiatric Hospital, and the Wisconsin Psychiatric Association. Info: Susan R Reichard, Mount Sinai Medical Center, 950 N 12th St, PO Box 342, Milwaukee, Wis 53201; ph 414/289-8026. (Further details elsewhere in this section.)

JUNE 10-11, 1982: *New Therapeutics in Cardiology and Infectious Diseases,* Madison. Sponsored by University of Wisconsin-Extension, Dept of Continuing Medical Education; and University of Wisconsin, School of Medicine, Dept of Medicine. AMA Category 1, AOA Category 2-D; AAFP, University of Wisconsin-Extension Continuing Education Units. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

JUNE 14-18, 1982: *Cardiac Rehabilitation Workshop,* La Crosse. See details elsewhere in this section.

JUNE 16-19, 1982: Annual Scientific Assembly of the Wisconsin Academy of Family Physicians, Radisson Hotel, La Crosse. Approved 20 credit hours Category 1 of AMA-PRA. Info: Robert H Herzog, Wisconsin Academy of Family Physicians, 850 Elm Grove Rd, Elm Grove, Wis 53122; ph 414/784-3656.

JUNE 17-23, 1982: *Fifteenth Annual Postgraduate Course in Gynecological Pathology, Cytogenetics and Endocrinology,* Pfister Hotel and Tower, Milwaukee. Sponsored by The Medical College of Wisconsin, Milwaukee. Fee: $500 enrollment fee will include 68 selected 35mm slides. Approved 42 credit hours of Category 1 of AMA-PRA and AAFP. Info: Richard F Mattingly, MD, Medical College of Wisconsin, 8700 West Wisconsin Ave, Milwaukee, Wis 53226.

JUNE 18-19, 1982: *Advances in Developmental Abnormalities: Clinical, Genetic, Radiological, and Pathologic Aspects* Madison. Sponsored by University of Wisconsin School of Medicine and University of Wisconsin-Extension, Continuing Medical Education. Approved 11 credit hours Category 1 of AMA and Extension Continuing Education Hours. Fee: $140. Info: Sarah Z Aslakson, Continuing Medical Education, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

JUNE 24-25, 1982: *Obstetrical Events and Neonatal Brain Injury,* Wisconsin Center, Madison. Sponsored by Continuing Medical Education, Health Sciences Unit, University of Wisconsin-Extension and Departments of Family medicine and Practice, Pediatrics, Gynecology and Obstetrics, School of Medicine, University of Wisconsin, Madison, and Madison General Hospital and St Marys Hospital Medical Center. Twelve credit hours, AMA; AOA; CEU's ACOG applied for. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

JULY 12-16, 1982: *Cardiac Rehabilitation Workshop,* La Crosse. See details elsewhere in this section.

JULY 16-17, 1982: Wisconsin Society of Obstetrics and Gynecology, Leathem Smith Lodge, Sturgeon Bay.

AUGUST 6-8, 1982: Wisconsin Dermatological Society summer meeting, Lake Geneva, Wis. Info: Robert A McDonald, MD, 1313 Fish Hatchery Rd, Madison, Wis 53715.

WISCONSIN SPECIALTY SOCIETY MEETINGS: 1982

Wisconsin Urological Society, Apr 30-May 1, 1982, Concourse Hotel, Madison

Wisconsin Chapter: American Academy of Pediatrics, May 23-25, 1982, Playboy Club, Lake Geneva

Wisconsin Academy of Family Physicians, June 17-20, 1982, Radisson Hotel, La Crosse

Wisconsin Society of Obstetrics & Gynecology, July 23-24, 1982, Leathem Smith Lodge, Sturgeon Bay

Wisconsin Neurological Society, Fall (September ?) 1982

Wisconsin Surgical Society, Sept 9-10, 1982, Holiday Inn and/or Radisson Hotel, La Crosse

Wisconsin Society of Internal Medicine, Sept 9-11, 1982, Holiday Inn (Downtown), Green Bay

Wisconsin Society of Anesthesiologists, Sept 9-12, 1982, Concourse Hotel, Madison

Wisconsin Radiological Society, Oct 16, 1982 Concourse Hotel, Madison

Wisconsin Allergy Society, Oct 17-18, 1982, Pioneer Inn, Oshkosh

Wisconsin Chapter: American College of Emergency Medicine, October 1982, The Pfister Hotel & Tower, Milwaukee

* * *

SPECIALTY SOCIETY MEETINGS TO BE HELD IN CONJUNCTION WITH SMS ANNUAL MEETING, May 13-15, 1982, Milwaukee

Wisconsin Allergy Society
Wisconsin Orthopaedic Society
Wisconsin Society of Internal Medicine
Wisconsin Society of Pathologists
Wisconsin Society of Physical Medicine and Rehabilitation
Wisconsin Society of Plastic Surgeons
Wisconsin Society for Preventive Medicine
Wisconsin Society of Radiation Oncologists
Wisconsin Surgical Society

Cardiac Rehabilitation Workshops

Offered through the joint effort of the La Crosse Exercise Program and La Crosse Lutheran Hospital/Gundersen Clinic, Ltd, six times throughout the year as follows:

March 1-5	**June 7-11**	**July 12-16**
April 19-23	**June 14-18**	**Sept 20-24**

Workshops provide an indepth understanding and experience of all aspects of cardiac rehabilitation and a thorough understanding of the organizational and administrative aspects of a cardiac rehabilitation program. Workshops will consist of didactic lecture with structured laboratory experiences and examinations. Accreditation through a number of agencies is offered. For further information contact:

Dr Philip K Wilson, Workshop Unit-La Crosse Exercise Program, Mitchell Hall/University of Wisconsin-La Crosse, La Crosse, Wis 54601; phone 608/785-8686

SEPTEMBER 9-11, 1982: Wisconsin Society of Internal Medicine and American College of Physicians joint meeting, Holiday Inn Downtown, Green Bay. Info: Kim Marggraf, Wisconsin Society of Internal Medicine, 611 East Wells St, Milwaukee, Wis 53202.

SEPTEMBER 20-24, 1982: *Cardiac Rehabilitation Workshop,* La Crosse. See details elsewhere in this section.

OCTOBER 16, 1982: Wisconsin Radiological Society, Concourse Hotel, Madison.

OTHERS

APRIL 14-15, 1982 (Michigan): *Designer Genes; 1982 Michigan Conference on Maternal and Perinatal Health,* Grand Rapids. Sponsored by the Michigan State Medical Society and seven other medically-related organizations. Approved 11 credit hours of Category 1 AMA-PRA and AAFP. Info: Michigan State Medical Society, Dept of Communications, 120 W Saginaw, East Lansing, Mich 48823; ph 517/337-1351. (See ad elsewhere in this issue.)

APRIL 28-30, 1982 (Indiana): *Endocrinology and Diabetes for the General Internist,* Indianapolis. Info: Registrar, American College of Physicians, 4200 Pine St, Philadelphia, PA 19104.

MAY 16-20, 1982 (Brazil): *The Fifth International Symposium on the Prevention and Detection of Cancer, San Paulo, Brazil.* Sponsored by Fundacao "Centro de Pesquisda de Oncologia" and The International Society for Preventive Oncology; Info: Medical Congress Coordinators Department, 1212 Avenue of the Americas, New York, NY 10036; ph 212/840-0110. g8-12/81; 1-4/82

MAY 19-22, 1982 (Florida): *Twenty-second International Conference on Legal Medicine,* sponsored by American College of Legal Medicine, at Boca Raton Hotel and Club, Boca Raton. Info: American College of Legal Medicine, 875 North Michigan Ave, Suite 3744, Chicago IL 60611.

MAY 21-22, 1982 (Iowa): *Midwest Conference on Health Care in the Elderly,* Fifth Annual Meeting, Iowa City. Sponsored by The University of Iowa College of Medicine, Departments of Internal Medicine and Family Practice, and the Iowa Gerontology Project. Two-day meeting of varied presentations of many aspects of geriatric medicine. AMA Category I credit, 15.5 hours. For additional information: Ian M Smith, MD, Dept of Internal Medicine, University of Iowa Hospitals, Iowa City, Iowa 52242; ph 319/356-2727. g3-4/82

JUNE 2-4, 1982 (Illinois): *Problem Solving in Lung Disease: A Practical Approach,* Chicago. Info: Registrar, American College of Physicians, 4200 Pine St, Philadelphia, PA 19104.

JUNE 14-16, 1982 (Canada): *Critical Care Medicine-1982,* Banff, Alberta. Info: Registrar, American College of Physicians, 4200 Pine St, Philadelphia, PA 19104.

JUNE 17-19, 1982 (Texas): *Review of Internal Medicine-1982,* Houston. Info: Registrar, American College of Physicians, 4200 Pine St, Philadelphia, PA 19104.

JUNE 26-JULY 10, 1982 (Austria/Monaco): *XIIth World Congress on Sports Medicine* in Vienna, Austria June 26-July 4 and *Post Congress Symposium* in Monte Carlo, Monaco, July 4-10. "Practical Application of Sports Medicine for Physicians, Trainers, and Coaches." Contact PO Box 66, Shawnee Mission, Kansas 66201 or call 800-255-6969. 2-5/82*

JULY 29-AUGUST 1, 1982 (Illinois): *International Doctors in Alcoholics Anonymous, Annual Meeting.* Hotel reservations directly at Ramada the O'Hare Inn, 6600 N Mannheim Rd, Des Plaines, Ill 60018 or call 312/827-5131 or 800/288-2828. (Be sure to specify IDAA for special rates). Further information contact Secretary IDAA, 1950 Volney Rd, Youngstown, Ohio 44511; ph 216/782-6216. g2tfn/82

AMA

JUNE 13-17, 1982: Annual AMA House of Delegates, Downtown Chicago Marriott, Chicago, Ill.

JUNE 19-23, 1983: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 4-7, 1983: Interim AMA House of Delegates, Los Angeles, CA.

DECEMBER 5-8, 1982: Interim AMA House of Delegates, Miami Beach, Fl. ■

SUMMER CME CRUISE/CONFERENCES ON LEGAL-MEDICAL ISSUES

Ten-day Caribbean cruise departs July 28, 1982 visiting five picturesque islands. 14-day Mediterranean cruise departs August 21, 1982 visiting Italy, Greece, Egypt, Israel, Turkey, Yugoslavia. Seminars led by distinguished professors. Approved for 24 CME Category I credits. Excellent Fly/Cruise group fares on finest ships. Both conferences, scheduled prior to 12/13/80, conform to IRS tax deductibility requirements under 1976 Tax Reform Act. Registration limited. For color brochures contact: International Conferences, 189 Lodge Ave, Huntington Station, NY 11746. Phone 516/549-0869. p3/82

University of Minnesota
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January-July, 1982

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Allergy and Clinical Immunology ..... Apr 29-May 1
Tissue Specific Antigens: An International Conference ..... May 3-5
Human Aging V ..... May 5-6
Medical Directors Spring Meeting ..... May 7
Family Practice Review: Update 1982 ..... May 10-14
Current Concepts in Radiation Therapy ..... May 19-21
Topics and Advances in Pediatrics ..... May 24-25
Biotechnology Symposium ..... May 26-28
Coronary Heart Disease Workshop ..... Jun 2-4
Management of Musculoskeletal Tumors (Annual Orthopaedic Surgery Conference) ..... Jun 9-11
Clinical Hypnosis ..... Jun 11-12
Advances in Vascular Surgery: 46th Annual Surgery Course ..... Jun 14-16
The Disabled Adolescent ..... Jun 29-30
Malnutrition: The Clinician's Role ..... Jul 9-10

Accreditation: All courses are approved for AMA/ACCME Category I credit and, as appropriate, by specialty societies.

For advance information and registration, write or call: Continuing Medical Education, University of Minnesota, Box 293 Mayo Memorial Bldg, 420 Delaware St, SE, Minneapolis, MN 55455; ph 612/373-8012. 1-3/82

News You Can Use

By EARL THAYER, Secretary / BERNIE MARONEY, Assistant Secretary

PHYSICAL THERAPISTS QUESTION LEGALITY OF EMPLOYMENT. The Wisconsin Attorney General has been asked to rule on an opinion request from the Physical Therapy Examining Council of the Medical Examining Board which suggests that employment of physical therapists by service corporations may be illegal and that their salaries in such cases may violate the fee-splitting statutes. The State Medical Society has filed informational evidence refuting both views. An opinion is expected within a few weeks.

IMMUNIZATION LAW WORKING WELL. Verification reports compiled by State Division of Health staff show Wisconsin's new Student Immunization Law to be working well. During the 1980-1981 school year, DOH Immunization Program staff visited 40 schools in 17 counties to verify compliance data. Immunization records on file at the schools were compared to medical records maintained by healthcare providers. For kindergarten students, physicians' records confirmed that 99 percent of those listed as meeting minimum requirements had actually received all the vaccines. However, 12 percent of high school students listed as being completely immunized did not meet requirements, primarily because they had been immunized against measles before their first birthday. A check of students with personal conviction waivers showed that 75 percent of parents choosing this waiver were not opposed to immunization. Most were unable to locate records by the 30 days after admission deadline, or thought that their children had previous measles disease. The survey also showed that students were non-compliant primarily because parents were still struggling to locate records. About 10 percent of parents were confused about what the law required them to do. About 3 percent of the school population was referred to district attorneys for legal action.

PTs NOT LICENSED FOR NEEDLE ELECTRODE USE. The Wisconsin Medical Examining Board has ruled that "the use of needle electrodes by physical therapists in the performance of electromyography testing is beyond the scope of the practice of physical therapy." The declaratory ruling, issued January 21, 1982, was in response to an inquiry by the Wisconsin Physical Therapy Association which hinted at a hearing that it would seek legislation to get around the Board's ruling.

HIGH COURT RULES ON LAWYERS ADVERTISING. Advertsing by lawyers may not be restricted as long as it is not "misleading," the US Supreme Court has ruled. The ruling, which probably will apply to advertising by other professions, invalidates several restrictions placed on lawyers' advertising by the Missouri Supreme Court. In a unanimous decision, the court said that states could interfere with lawyers' right to advertise only to the extent of protecting consumers from misleading advertising. It said the First Amendment did not permit states to limit advertising just because it had the potential to be misleading. State restrictions must apply to advertising and promotional materials that are "inherently misleading" or that have "proven to be misleading in practice," the court ruled.

CPI SHOWS SIZABLE INCREASE IN PHYSICIAN CHARGES FOR 1981. Charges for physicians' services rose 11.7% in 1981, according to the government's Consumer Price Index. The figure for the physicians' services component of the Index was higher than the 8.9% increase in the all-items component and lower than the 13% rise in all services during the year. The medical care index went up 12.5% in 1981. It was the only CPI category to show an increase over the 1980 figure. In 1980 medical care rose 10%, compared to 12.4% for all items and 14.2% for all services. The physicians' services figure for 1980 was 11%. Other rates of increase in the medical care index, with 1980 figures in parentheses, were prescription drugs, 12.6% (9.8%); dental services, 10.2% (10.7%); medical care commodities, 11.3% (10%); and hospital room charges, 17% (13.9%).

WISPRO TO HANDLE REVIEW FOR TITLE 19 PATIENTS. The State of Wisconsin February 16 signed a contract with the Wisconsin Professional Review Organization (WisPRO) to administer a hospital utilization review program for Title 19 patients within WisPRO's jurisdiction. Prior to this agreement, WisPRO had administered Medicaid utilization review in tandem with Medicare review through provisions of the Social Security Act. This transition to a state-directed program comes as a result of recent changes to the federal PSRO law. ■

Bactrim™
(trimethoprim and sulfamethoxazole)
succeeds

Bactrim is useful for the following infections when due to susceptible strains of indicated organisms (see indications section in summary of product information):

Expanding its usefulness in antimicrobial therapy

in recurrent UTI...
a continuing record of high clinical effectiveness against common uropathogens

in acute otitis media in children...
effective against both major otic pathogens...with *b.i.d.* convenience

in acute exacerbations of chronic bronchitis in adults...
clears the sputum and lowers its volume...on *b.i.d.* dosage

in shigellosis...
faster relief of diarrhea than with ampicillin[2]

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. Limited clinical information presently available on effectiveness of treatment of otitis media with Bactrim when infection is due to ampicillin-resistant *Haemophilus influenzae*. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.

For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.

For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age

Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended, therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: *General:* Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L E phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:

Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.

Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.

For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.

ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:

Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days.

PNEUMOCYSTIS CARINII PNEUMONITIS:

Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100; Prescription Paks of 20 and 28. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40. *Pediatric Suspension,* containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); cherry-flavored—bottles of 100 ml and 16 oz (1 pint). *Suspension,* containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).

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Bactrim continues to demonstrate high clinical effectiveness in recurrent urinary tract infections. Bactrim reaches effective levels in urine, serum, and renal tissue[1]...the trimethoprim component diffuses into vaginal secretions in bactericidal concentrations[1]... and in the fecal flora, Bactrim effectively suppresses Enterobacteriaceae[1,2] with little resulting emergence of resistant organisms.

1. Rubin RH, Swartz MN: *N Engl J Med 303* 426-432, Aug 21, 1980. **2.** Data on file, Medical Department, Hoffmann-La Roche Inc.

Bactrim™ DS
160 mg trimethoprim and 800 mg sulfamethoxazole
DOUBLE STRENGTH TABLETS

maximizes results with B.I.D. convenience

ROCHE®

*due to susceptible strains of indicated organisms

Please see previous page for summary of product information.

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WISCONSIN MEDICAL JOURNAL

APRIL 1982

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ONE OF THE VITAL SIGNS OF ANXIOUS DEPRESSION:

INSOMNIA

Others to look for:

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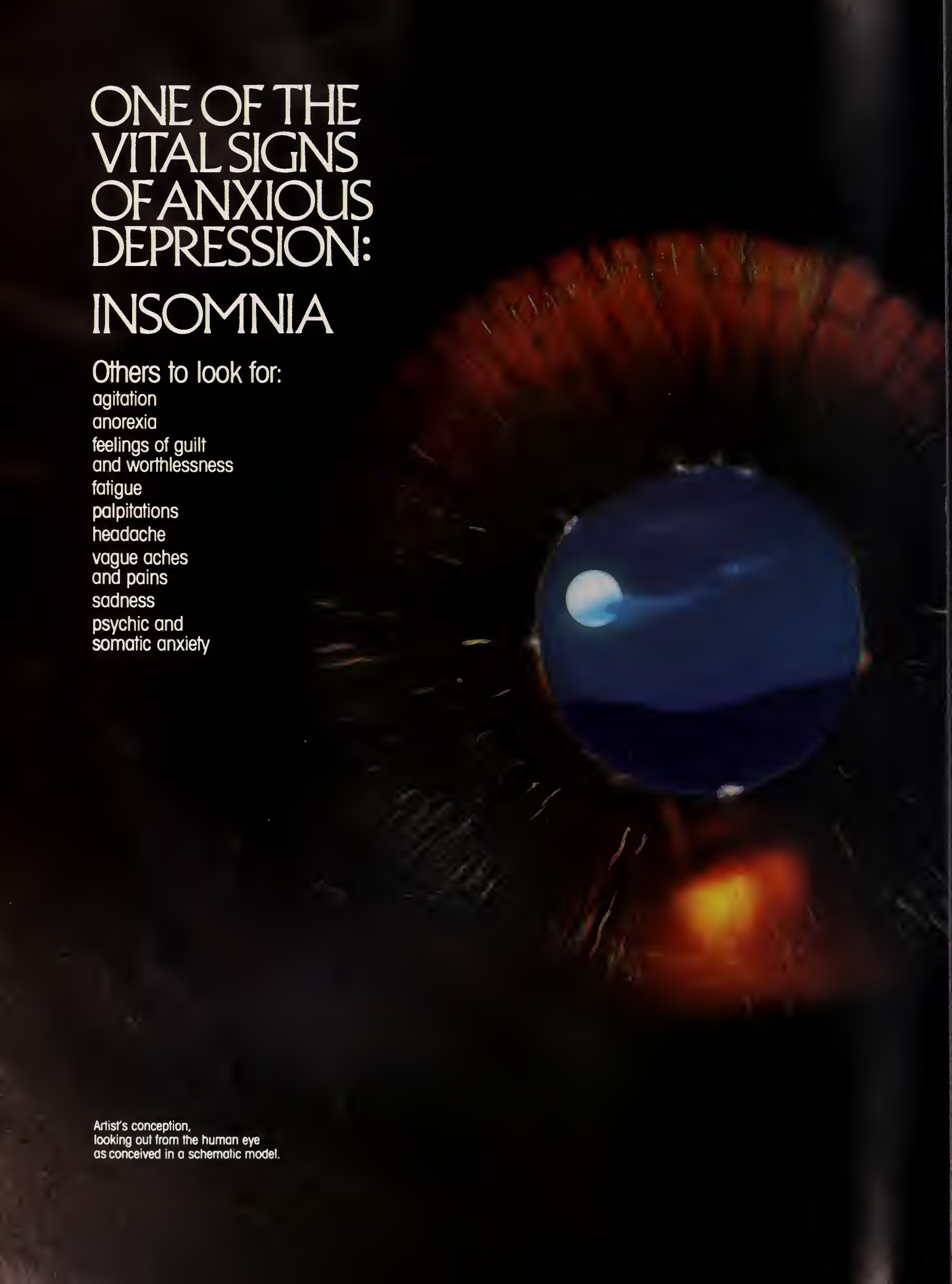

Artist's conception,
looking out from the human eye
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LIMBITROL GIVEN H.S.: ONE OF THE VITAL SPECIFICS OF TREATMENT

Limbitrol brings a special—and specific—quality of relief to most anxious depressed patients. Insomnia, for example, responds with particular promptness. Other symptoms likely to respond within the first week of treatment include anorexia, agitation and psychic and somatic anxiety. And, as the depression and anxiety are alleviated, in many cases so are such related somatic symptoms as headache, palpitations, and various vague aches and pains.

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Many patients respond readily to a single bedtime dose of Limbitrol, a convenient schedule that may enhance compliance and helps relieve the insomnia associated with anxious depression. Limbitrol also offers a choice of other regimens: t.i.d., or a divided dose with the larger portion h.s. In all cases, caution patients about the combined effects with alcohol or other CNS depressants and about activities requiring complete mental alertness, such as driving or operating machinery.

in moderate depression and anxiety

Limbitrol® 5/12.5 10/25

Tablets 5-12.5 each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)
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Specific therapy with h.s. dosage convenience

Please see summary of complete product information on following page.

LIMBITROL® TABLETS Tranquilizer—Antidepressant
Before prescribing, please consult complete product information, a summary of which follows:
Indications: Relief of moderate to severe depression associated with moderate to severe anxiety
Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use; then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.
Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).
***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).
Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.
Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.
The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:
Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.
Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.
Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.
Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.
Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.
Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.
Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.
Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels.
Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.
Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.
Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly. Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased to six tablets or decreased to two tablets daily as required. Limbitrol 5-12.5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses.
How Supplied: White, film-coated tablets, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500, Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50.

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Publication Information

MANUSCRIPTS. Manuscripts will be accepted for consideration with the understanding that they are original, have never before been published, and are contributed solely to the WISCONSIN MEDICAL JOURNAL. The Editorial Board reserves the right to limit manuscripts to two printed pages, with additional pages to be subsidized by the author(s) on the basis of $100 per page. A maximum of four illustrations and/or tables may be included; additional ones will be charged to author(s) at cost. Address manuscripts to Medical Editor, Wisconsin Medical Journal, Box 1109, Madison, Wis 53701.

Rejected manuscripts are returned by regular mail. Accepted manuscripts become the property of the JOURNAL and are not returned. Submit one original and two carbon copies. Author should retain one carbon copy. Format and style should follow that of the *AMA Style Book and Editorial Manual.* Manuscripts are subject to editorial modification and such revisions as bring them into conformity with JOURNAL style.

Contributors will be sent a copy of their article after it has been edited and set in type for final approval before publication. A form for ordering reprints will accompany the article.

Under ordinary circumstances manuscripts are published about six months following acceptance, and in the order in which they are received.

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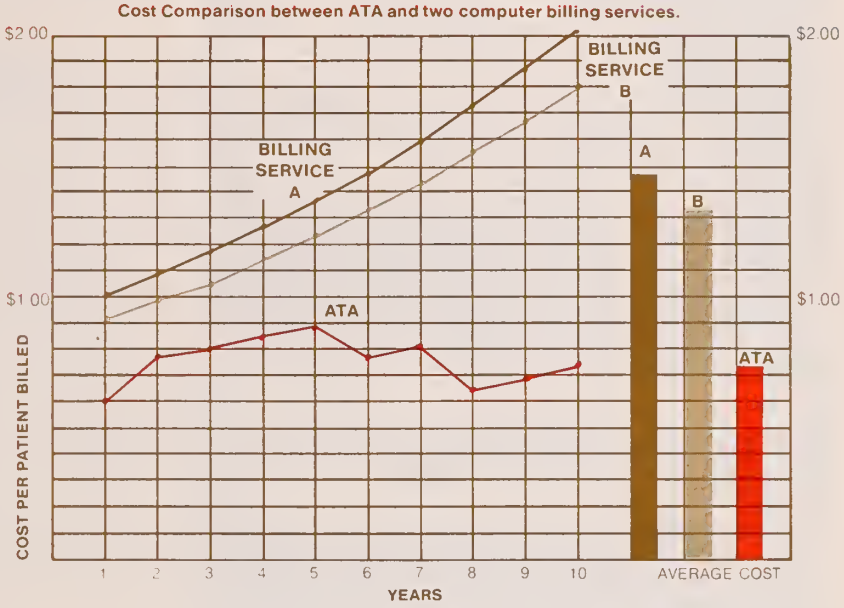

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Medical computer systems

President's Page

ALBERT J MOTZEL JR, MD

It is now clear that the economic times we are going through are likely to be more devastating and more prolonged for many of our fellow citizens than we had anticipated. While many of us believe this period of readjustment is probably necessary in our economy after many years of excesses, this period places a significant burden on a profession such as medicine. No one will deny that the medical profession is first and foremost one of service. While physicians deserve adequate compensation for long and arduous years of training and hours of practice, the very nature of their calling creates some obligation to render service regardless of compensation. (The ability to pay is not always commensurate with the immediate need of the individual.) This obligation has been blurred by our affluent society's insistence that society as a whole should shoulder this burden. It is likely that society can never accomplish this without ludicrous excesses in some areas and dismal shortcomings in others. But in our current times, it is obvious that many are going to suffer needs which "society" will not meet. I would like to introduce two considerations by which the medical community might fulfill its obligation to serve in these times:

1 The "free clinic"

There are two projects that are in various stages of development which I would recommend to physicians in Wisconsin for emulation in many of their communities—the "free clinic." This is a concept which is subject to much misinterpretation. It means many things to many people.

In the early 1970s in Waukesha County a sizable group of people spent many hours over six to eight months attempting to create a means of entry into the main stream of medical care for members of the community—those who either did not have the resources or the understanding of the system. This effort ultimately failed. At the same time a somewhat analogous effort made in Green Bay met with greater success, and it continues to produce seemingly salutary results. More recently a renewed effort in Waukesha has met with greater success. While neither of these endeavors may be perfect, or meet with universal approval, nevertheless in our present economic times it is reasonable that the medical profession should participate with others to see that some (perhaps an increasing number) do not suffer the lack of needed care because they fall outside of the scope of present programs.

To succeed I believe such an organization must be voluntary; it must have physician involvement from its inception; it must adequately screen clients financially early in the process and refer those eligible for benefits to appropriate agencies and give them proper help; and it must refer fairly, after initial screening, those who are not eligible for other programs and who cannot afford private care, to appropriate physician volunteers. It *must not be* an organization whose purpose is to experiment with change in the system of delivery of medical care; if it is, it will surely fail in this time of need. If these criteria are met, such organizations deserve the support of the physician community and all physicians individually. If this support is forthcoming, it is also incumbent upon institutions such as hospitals and private commercial laboratories to participate in such programs. Physician involvement and support of such a voluntary organization can play a vital role in purveying good medical care to those individuals or families temporarily unable to pay all or part of the cost of the care they need. If physician support is not forthcoming, these same people are in danger of receiving no care or medically unsound care with the potential of becoming chronic recipients of more costly tax-supported programs. Although each community must explore its own needs and formulate its own solutions, the suggestions I have made here could be useful general guidelines.

2 Voluntary restraint

We are seeing today, for the first time in many decades, economic conditions that are causing many in the work force to reconsider the demands of recent times for an ever-increasing standard of living. For many employees it has become more important to remain employed than to outdistance the rate of

inflation as economic indices portray. For the first time in recent memory large union contracts are resulting in even diminished salaries for large numbers of employees. In economic times such as these it seems inappropriate for physicians not to participate in the restraint increasingly prevalent in the economy generally. Like in all other matters requiring sacrifice it is easy for each of us to justify why we might consider ourselves an exception. It is perhaps much more important that each of us understands why some degree of sacrifice must be distributed among us all. It is also tempting because of the timing of implementation of fee increases to assume that what was done in good faith several months ago has already been accomplished, and we will be restrained six, eight, or ten months in the future if times have not improved. This really fails to fulfill the spirit of such restraints. Without defining a precise mechanism perhaps it would be realistic to suggest that individual fees at this time and through the remainder of this year should not exceed the same period in 1981 by more than three or four percent. This type of restraint on a voluntary basis, by the physicians as individuals would be far superior to the prescribed ("allowed") fee increases used for advertising and public relations purposes by some local insurance carriers who sell their contracts under the erroneous guise of paying usual, customary, and reasonable (UCR) fees.

It is time for all physicians to give the above or similar suggestions real consideration and individual as well as organizational support. ■

* * *

AMA Video Clinic Library. More than 50 hours of Category 1 CME credit are now available through the 18 programs offered by the AMA Video Clinic Library. "Common Skin Disorders: The Office Approach" is the latest of these in-depth courses designed for individual or small group study in the home, office, or hospital. Some other courses are "Primary Care of Common Sexual Problems," "Chronic Obstructive Pulmonary Disease," and "Antibiotic Therapy in Office Practice." The 18 clinics are two-to-six hour courses containing a complete analysis of physiology, etiology, diagnosis, treatment, and prognosis. The programs may be rented or purchased. Each consists of a color video tape, illustrated study guide, and self-assessment tests. For information on the programs and charges, contact Division of Marketing and Meeting Services, AMA Headquarters, (312) 751-5951. ■

Placement Registers. The AMA's two "Placement Registers" began bimonthly publication in February. The "Opportunity Placement Register" lists more than 1,100 medical practice opportunities for physicians. The "Physician Placement Register" lists 1,700 physicians looking for new positions. For the past four years the registers, which are the key to the AMA Physicians' Placement Service computerized information bank, have been published quarterly. The February registers are now available. For information, contact Physicians' Placement Service, AMA Headquarters, (312) 751-6282. ■

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Impaired physicians

IN OCTOBER 1981 the State Medical Society sponsored a Conference on the Impaired Physician. Wisconsin has pioneered in recognizing and coping with the problem of impaired physicians.

We are indebted to Dr Barry Blackwell, Professor and Chairman Department of Psychiatry (Milwaukee), University of Wisconsin Medical School. He undertook the task of shortening by approximately 50 percent the manuscripts that were presented at the conference. He edited and removed the repetitious material that is inevitable in a series of papers such as this.

This entire issue of the *Wisconsin Medical Journal* is devoted to the subject of the impaired physician.

—VSF

Deadbeat doctors

MOST PHYSICIANS are aghast at recent national news stories reporting that some 5,000 MDs have reneged on student loan obligations.

The story gets no better closer to home. The State Medical Society's Charitable, Educational and Scientific Foundation (CESF) currently has 74 physicians overdue on loans from their student years to the tune of almost $95,000. The loans are due two years after graduation and for most of the delinquent loanees the due date occurred six to seven years ago.

Among the 74 are five owing about $9,000 who are overdue and presumed lost because they cannot be located anywhere in the United States.

Another 11 still owe $7,600, having been pursued for six or more years by a variety of means including referral to collection agencies.

Still another four owing $5,200 are overdue by several years, have been referred for collection, and still no payment is in sight.

Loans to another 54 physicians totaling nearly $73,000 are overdue from two to six years. Since polite requests for payment have been ignored, they are now being referred to collection.

Even though some 500 loanees have repaid their CESF loans in full over the past 30 years, it is deeply disturbing to discover that 94 out of 256 current loanees are copping out on their signed loan agreements.

It's bad news that these deadbeats are denying other medical students the opportunity of obtaining financial help in times even more troubled than those they experienced. Worse is the realization that so many of the professionals being turned out to practice today are so unprincipled as to ignore the basic precept of honesty between fellow human beings. How dare these physicians ask for trust from their patients or colleagues? With examples like the 74, little wonder that government and public lose respect for physicians.

It is of no comfort to realize that Wisconsin is not alone in having deadbeat doctors. The vast majority of honest, dedicated physicians are shamed and agonized by the indecency and dishonesty of a few. The penalty for the deadbeat should be disenfranchisement.—ERT

AB 941

BETTY JO NELSEN, Representative from the Tenth Assembly District, has introduced legislation (AB 941), now passing through the public hearing process. It is of special interest to surgeons.

A December press release from Rep Nelsen's office states:

NELSEN SPONSORS PHYSICIAN DISCLOSURE BILL

"MADISON . . . Legislation that would help women make informed choices about breast cancer treatment has been introduced in the Assembly by State Representative Betty Jo Nelsen (R-Shorewood). Nelsen's bill would require physicians to inform patients about the availability and feasibility of alternative methods of treatment. Failure to make such disclosures could subject the physician to disciplinary measures for unprofessional conduct.

"Breast cancer patients are frequently told only about extensive surgical procedures which have been practiced for many years, and not about less radical treatment that preserves much more healthy tissue," Nelsen explained. The *New England Journal of Medicine* has published an Italian study showing that relatively minor surgery followed by radiation treatment can be as effective as radical mastectomy in treating breast cancer, provided the disease is detected in an early stage. An estimated 2,400 new cases of breast cancer are identified each year.

"Women's concern is a major factor in early detection of this disease and they ought to be able to participate fully with their doctors in deciding what treatment best meets their medical and emotional needs," Nelsen said. "Legislation requiring full disclosure of treatment methods will ensure the patient's having a voice in dealing with her condition."

Nelson noted that the bill parallels a 1975 Wisconsin Supreme Court decision citing a physician's duty to disclose to a patient whatever information is needed for the patient to exercise the right to accept or refuse treatment.

The bill itself makes no mention of women or breast cancer specifically. It is quite short as bills go:

SECTION 1. 448.02 (3) (intro.) of the Statutes is amended to read:

448.02 (3) INVESTIGATION; HEARING; ACTION. (intro.) The board shall investigate allegations of unprofessional conduct by persons holding a license or certificate granted by the board. A finding by a panel established under s. 655.02 or by a court that a physician has acted negligently is an allegation of unprofessional conduct. *An allegation that a physician has violated s. 448.30 is an allegation of unprofessional conduct.* After the investigation, if the board finds that there is probable cause to believe that the person is guilty of unprofessional conduct, the board shall hold a hearing on such conduct, warn or reprimand that person, or limit, suspend or revoke any license or certificate granted by the board to that person. The board shall comply with rules of procedure for such investigation, hearing and action promulgated under s. 440.03 (1)

SECTION 2. 448.30 of the Statutes is created to read:

448.30 INFORMATION ON ALTERNATE MODES OF TREATMENT. Any physician who treats a patient shall inform the patient about the availability of all alternate, viable medical modes of treatment and about the benefits and risks of these treatments. The physician's duty to inform the patient under this section does not require disclosure of:

(1) Information beyond what a reasonably well-qualified physician in a similar medical classification would know.

(2) Detailed technical information that in all probability a patient would not understand.

(3) Risks apparent or known to the patient.

(4) Extremely remote possibilities that might falsely or detrimentally alarm the patient.

(5) Information in emergencies where failure to provide treatment would be more harmful to the patient than treatment.

(6) Information in cases where the patient is incapable of consenting.

SECTION 3. 448.40 of the Statutes is amended to read:

448.40 RULES. The board may adopt rules pursuant to ch. 227 to carry out the purpose of this chapter. *The board shall adopt rules to implement s. 448.30.*

The Medical Society opposes the bill on the grounds that the subject is already dealt with in case law on informed consent, and rightly so. But there is an even more fundamental objection.

Anyone who follows the medical literature on breast cancer treatment and reads material on that same subject in newspapers and magazines will realize that it forms a shaky foundation on which to build meaningful, lasting legislation. If the bill were passed and followed to the letter of the law, surgeons would have to spend more time talking about the various options in managing breast cancer than they would in treating it, and would wind up confusing the already anxious and upset patients beyond endurance.

Even the most intelligent, well-educated patient is not equipped to analyze the comparative values of the various approaches; and she must be guided so that she chooses the wisest course, based on the surgeon's knowledge and experience. Asking her to make a decision after having listened to a half dozen alternatives is cruel and represents an abdication of responsibility by the surgeon.

In point of fact, the bill is really unnecessary anyway, insofar as breast cancer is concerned. Most women are already aware of the existence of the alternatives, and they are probably the best-informed of all the surgical patients. They need only be shown what is best for them, and why, and that judgment must be based on a concensus of the best available reports—not a single, eye-catching article, the conclusions of which may be premature.—WJB

Call our law firm collect

WISCONSIN NEWSPAPERS have been deluged with ads seeking local clients. These ads state: "Our law firm will represent you on a contingent fee basis for one-third of the amount recovered. For a free initial consultation and advice on your claim, please call collect."

These ads are directed to the users of a particular IUD and suggest that the user of such a shield may still be able to take action against the IUD manufacturer.

Although this is within the province of the bar associations, the ad is perfectly legal the US Supreme Court has ruled. This is not the type of advertising that physicians should consider professional. The AMA has been involved in a nine-month long trial with the FTC. The AMA was the first professional organization to rewrite its ethical code following the Supreme Court's 1975 decision rejecting a state bar association's fee standard. The new AMA code limits restrictions against physician advertising to make unethical only advertising that is false, misleading, or deceptive.

The new AMA principle does not proscribe advertising but is designed to protect the public. Can we say the same for the current legal ad?—VSF■

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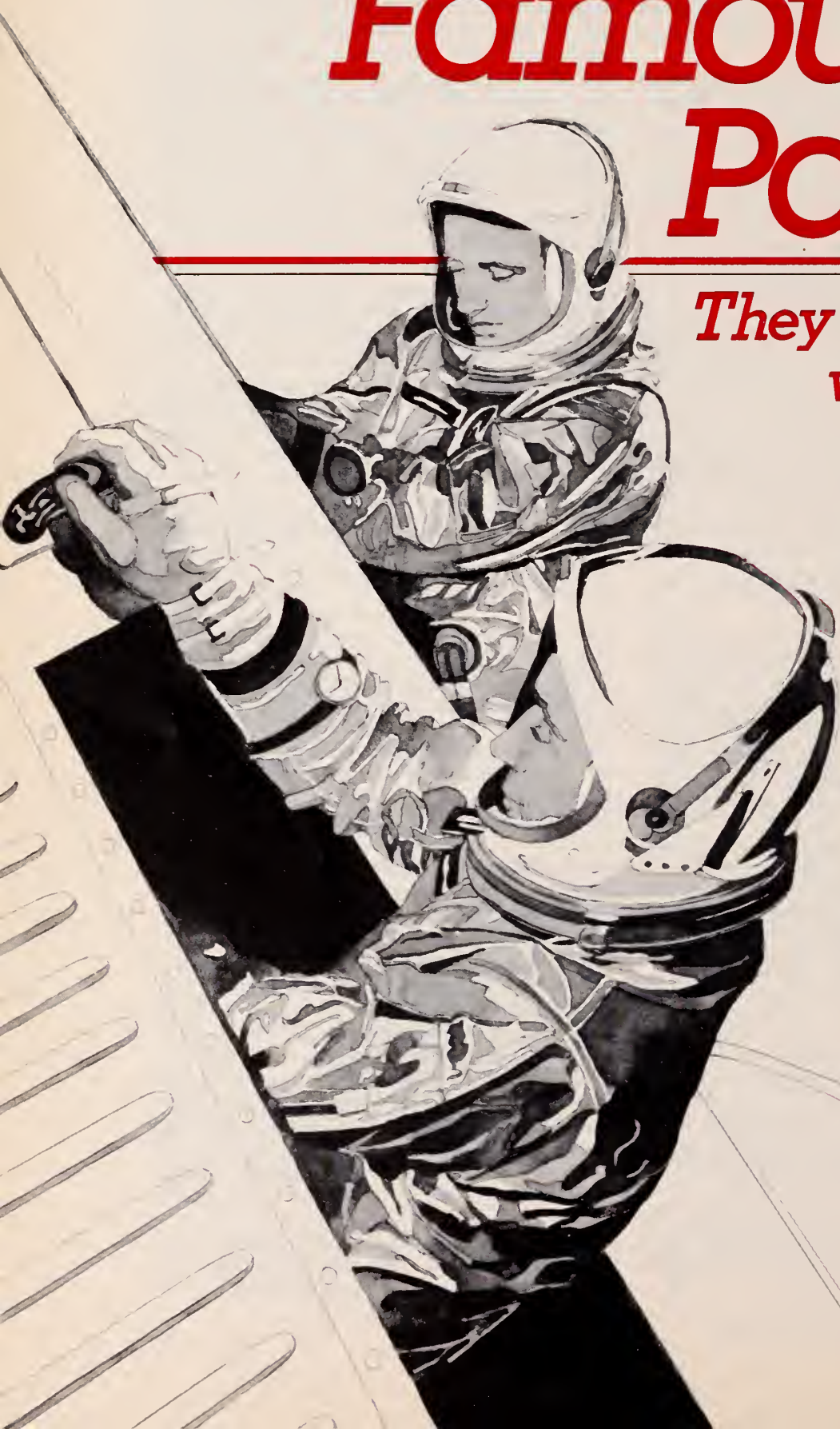

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**Meeting of Am Soc Colon / Rectal Surgeons, May 1980.*
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PD-85-JA-0867-P-1 (2-82)

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Pregnancy

See "WARNINGS"

Pediatric Use

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Commentary BY A SENIOR PHYSICIAN

Some random thoughts on the "Old Pediatrics"

H Kent Tenney, MD, Madison, Wisconsin

SEVERAL YEARS AGO some people spoke of "The New Pediatrics." I was never sure what they meant and I still don't know. But if they mean a shift in emphasis from 'home-office-laboratory' to 'office-laboratory' with very little on 'home,' then many of us old timers believe that the "new" is a step backward.

In the early and mid 1920s, many competent internists regarded pediatrics as internal medicine confined to a certain age group. This is a point of view that pediatricians never could accept. While it is perfectly true that many diseases are no respecter of age, the problems confronting the growing and developing human organism require a special dimension of understanding. And it is also true that many of these diseases have been brought under control by laboratory and clinical studies. Again it is true that some facets of growth and development can be measured in the office and laboratory. However, when it comes to the emotional growth and development of the child, the subtle influences of the intra-family relationships are of paramount importance.

To those of us who started practice in the early 1920s the rapidly vanishing "house call" was an integral part of practice. And I may say that this was one of the most rewarding. Most of the time we would go to a home filled with apprehension and leave it calmed down. Of course, there were times when we would say, "let's get to the hospital in a hurry," but knowing the family and how they reacted to different situations was a great help in making these decisions. This type of "knowing the family" can only be achieved by visiting the family in their home and watching for the degree to which some observable phenomena are present. Sibling rivalry, for example, is normal to a certain extent. However, if it leads to the parents being over-protective of one child, friction is quite sure to show up. The syndrome of "maternal deprivation" can be present even when both parents are present but the children get the feeling that the parents don't care what happens. In other words, they get the feeling of rejection, and there is nothing more devastating to a child's emotional development.

Another event in family life that may lead to undue sibling rivalry is the impending arrival of another child. This is a great event and should be so regarded. However, there are a few precautions that are worth observing. For one thing let's not be too specific about the sex of the new member. If we miss, it will only be by one, but that can be enough to make the incumbent of 'spot number one' feel that he has been double-crossed. Then, too, let's not overplay the theme "to play with" because it is inevitable that this is not going to be like any other toy he has been brought; one that he can squeeze, poke, and shake. On the contrary, his attempts at "to play with" are apt to be met with restraints if not actual rebuffs. Also when friends come to visit, they often bypass this former pal and make a fuss over the new intruder. All of these things can intensify the feeling that having a new baby in the house was a bad idea right from the start. To re-assert his position as 'number one' he must start a new line of behavior that is sufficiently bizarre to assure its being noticed. While every child wants the approval of his parents more than he wants anything else in the world, still some disapproval is better than being ignored.

What has all this to do with the "Old Pediatrics" and the old-time pediatrician? By virtue of the fact that he has visited all kinds of families, in all kinds of homes, under all kinds of conditions, he has encountered this situation many times. As a result he has

EDITORIAL COMMENT. Writing in the September 1981 issue of the *American Journal of Diseases of Children,* Lawrence R Berger, MD, a pediatrician with the University of New Mexico School of Medicine, Albuquerque, expressed similar views to those of Doctor Tenney: House calls, particularly for child patients, are better medical care. Visits to children's homes can be a valuable tool to assess the child's environment, observe the child in his or her own world, establish rapport with families, and learn about how the family functions. The value of house calls in provision of care to children has been neglected, Doctor Berger stated. He concluded the article in the American Medical Association's publication by stating that "by no means do all families in a pediatric practice require home visits." And the visit often can be delegated by the physician to a nurse practitioner or other assistant.

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developed the faculty of "thinking like a child" which helps him formulate plans of action. The underlying principle in all these plans is the fact that the one commodity, that can be divided into any number of parts without being reduced one bit, is parents' love for their children. This is particularly important when we are dealing with the second child. So when the baby cries, if we ask his opinion as to what might be wrong, it will help give him a feeling of importance. "Is he hungry or is he just lonesome?" When visitors come, ask if this is a good time for Mrs Smith to see the baby; and if so, will he take her over and show her how little the baby is, but now he is already starting to greet people with a smile.

These are small things but they will help the older one retain his feeling of importance and of being needed in the family and in this way lessen the traumatic impact of sibling rivalry.

At present we are hearing a good deal about "adolescent medicine" as though this was a specialty separate and distinct from pediatrics. This brings up the question of the age range covered by the pediatrician, which can have many variables. However, as I am speaking from the point of view of an old timer, I shall simply say how I did it: I used two criteria: (1) when the child said, in effect, "I don't want to go to a baby doctor any more;" (2) when I said, "Keep on coming as long as you want to; but if you get sick with something I don't understand, you will have to find another doctor and I will help you find one."

Now to sum up these random thoughts of an old-style and out-of-date pediatrician: (1) I deplore the demise of the "house call" which was such an integral part of our practice and which allowed us to truly know our families; (2) I am concerned about the possibility that the vast refinement in the laboratory study of the form and function of all organ systems may lead to a vast proliferation of specialties and subspecialties with the consequent fragmentation of the individual. In other words, the focus will shift from the patient who has a disease to the disease which the patient has; (3) The cost of basic and clinical research will become so great that governmental agencies will begin to demand quick answers which are not possible; *ie,* "If you can put a man on the moon, you ought to be able to cure cancer."

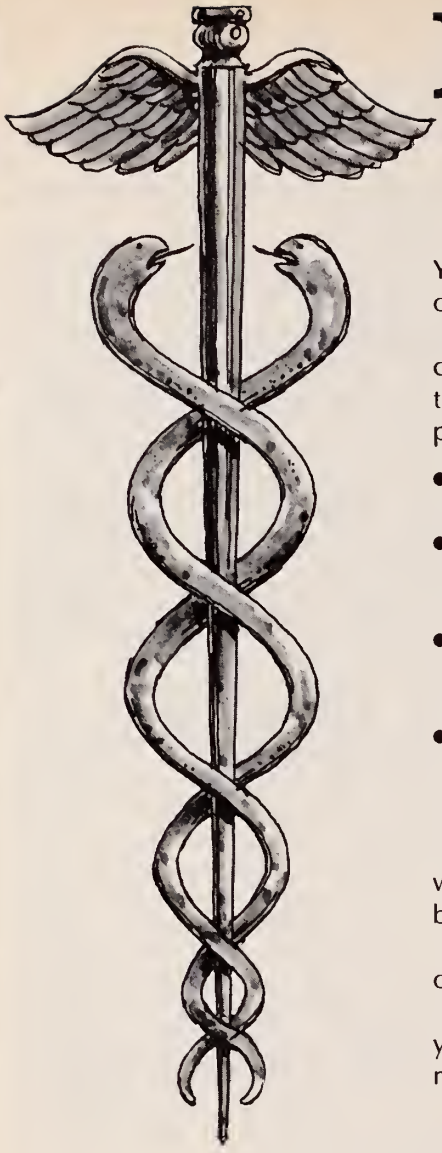
But, in spite of all the obstacles, the consoling thought is that all the young folks who choose medicine as a career do so with the finest of motives. ■

H KENT TENNEY, MD—A descendant of a pioneer Wisconsin medical family, grandson of a physician and father of a physician, Doctor Tenney was one of the first of his specialty—pediatrics—to begin a practice which has led to several related and distinguished careers. He probably is best known for his "March of Medicine" radio programs broadcast weekly over 45 state stations from 1960 until 1976 when he retired at the age of 83. He became known as the "family physician of the airways" whose compassionate and sympathetic ear was sought by thousands of people. Born in Chicago in 1892, a proud descendant of an Ottawa Indian chief, Doctor Tenney came to Madison in 1920 following graduation from Northwestern University Medical School and an internship at Evanston (Illinois) Hospital. He was an instructor at the University of Wisconsin Medical School, advancing to assistant professor and then clinical professor of pediatrics. A winner of the Medical School's Emeritus Faculty Award, Doctor Tenney was a tireless, traveling lecturer on behalf of the emotional and physical well-being of children. He was a stimulating force in the development of the child care projects known as "well baby clinics." He has been a widely read author, a writer of the popular book for young mothers, "Let's Talk About Your Baby," among others. Having set up a private practice in pediatrics in 1926, Doctor Tenney became active in affairs of organized medicine, serving as president of the Dane County Medical Society and the State Medical Society of Wisconsin. He was a delegate to the State Society's House of Delegates and was the House speaker. In 1969 he was given the Council Award of the State Medical Society, highest honor bestowed by the Society. Doctor Tenney served as chairman of the Governor's Conference on Children and Youth in 1953, having been medical consultant for the Bureau of Handicapped Children of the State Department of Public Instruction. "But with all these distinctions, he remains, as always, the compassionate practitioner, a true disciple of the fabled Hippocrates," as cited in the Council Award.

Doctor Tenney

PR kit on hypertension prevention offered

A kit of public information materials on hypertension is available from the National Heart, Lung, and Blood Institute in connection with the observance of "National High Blood Pressure Month" in May. The kit is aimed at helping physicians muster support for the observance from decision-makers, the media, consumers, and patients. For additional information and copies of the kit, write High Blood Pressure Month 1982, High Blood Pressure Information Center 120/80 National Institutes of Health, Bethesda, Md 20205.



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FIRST WISCONSIN

FWT-39

Letters

The Editors would like to encourage physicians to contribute to the LETTERS section where they can ventilate their frustrations as well as opinions. This feature is intended to be lively and spirited as well as informative and educational. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address correspondence to: The Editor, Wisconsin Medical Journal, Box 1109, Madison, Wis 53701.

A pharmacist responds

TO THE EDITOR: This is in response to your December 1981 editorial, "Everybody wants to play Doctor."

It is not difficult to understand the consternation of physicians regarding the proposed updating of the Wisconsin pharmacy law. With nurse practitioners, and physicians' assistants all doing things closely involved with the practice of medicine, one does get the feeling that everybody does want to play doctor.

I think the case in pharmacy is different. As you know, community pharmacists are easily accessible members of the healthcare team. As a result, triage becomes an important aspect of our community service and responsibility. Most pharmacists take this seriously and want the patient to receive proper medical care. Consequently, day in day out, we refer patients to physicians because we believe it is in the patients' best interest.

The reference in SB-437 regarding monitoring, initiating, administering or modifying drug therapy will continue to be under physicians' protocols and is simply recognizing current practices in pharmacy in Wisconsin and nationally. We are not trying to be physicians because most of us have enough to do being responsible pharmacists.

Regarding the other issue—licensing of physicians' drug rooms or dispensing physicians. Years ago drug abuse was not the problem it is today. All of us in healthcare, and physicians especially, should recognize the importance of good drug control. Clearly the great majority of physicians will not be touched by this legislation. Unfortunately, some physicians do not seem to think the off-handed manner in which they treat their sample and office drugs is part of the problem. Perhaps, as you say, the Medical Examining Board is not getting the job done. I'm sure your Society's efforts to encourage the Board could go a long way toward rekindling a new respect for drugs on the part of those physicians who have forgotten that fact.

Finally, it has been my experience that most pharmacists and physicians are reasonable people. I am sure that reviewing the facts together would result in a consensus acceptable to our colleagues and beneficial to the public.

Dennis Dziczkowski, RPh
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J-9043-4 July 1981

Special/Impaired Physician

SOME NOTABLE successes have been achieved by the State Medical Society's Impaired Physician Program since its inception in 1977. A number of physicians afflicted with some form of impairment have been encouraged by compassionate volunteer colleagues to leave their practices and enter structured rehabilitation programs. However, these few successes diminish quickly with the realization that many others continue fighting a lonely, losing battle against alcohol or other chemicals. Consider, too, those physicians suffering from emotional illnesses, physical impairment, or senility.

Studies show that physicians are better able to hide or mask their impairments than the general public. Physicians give credence to this by joining the "conspiracy of silence;" that is, they studiously avoid taking the necessary steps to intervene. Many physicians don't understand the extent of impairment among their colleagues. Those who do are quite unsure what to do about it. When should they act? Is it any of their business? How do they report an impaired colleague, and to whom? What are the risks?

The Coordinating Council on Physician Impairment, a cooperative effort of the State Medical Society of Wisconsin and the Wisconsin Medical Examining Board, works to exchange information of common interest and concern in matters of physician impairment, and to increase physician awareness of impairment through development of educational programs. On October 14-15, 1981 the Coordinating Council cosponsored a seminar designed to inform Wisconsin physicians and others about prevention of impairment, intervention with the impaired physician, and their subsequent rehabilitation. Moreover, a wide range of individuals, institutions, and agencies were identified because of their potential involvement with impaired physicians and their problems and concerns.

Probably the first of its kind and scope in Wisconsin, the seminar attracted an impressive number of practicing physicians, hospital chiefs-of-staff, county medical society officers, clinic representatives, hospital administrators and trustees, and others.

The following pages contain either complete transcripts or summaries of presentations from the October 1981 seminar. They are published for an obvious purpose of making physician readers of the WISCONSIN MEDICAL JOURNAL *aware* of the problem, and to encourage them to *do* something about it.

Gerald C Kempthorne, MD, Spring Green
President-elect, State Medical Society of Wisconsin
Cochairman, Coordinating Council on Physician Impairment

The Journal is most appreciative of the editing responsibility undertaken by Dr Barry Blackwell, Milwaukee, in preparing this material for publication and to Dr Harry Weisberg, Milwaukee, who was instrumental in program development of the October seminar.

1 The stress of medical education on medical students

Joanna H Spiro, EdD, Milwaukee, Wisconsin
Assistant Professor of Psychiatry, Medical College of Wisconsin

MOST OF US HAVE very high expectations of what a doctor should be and how he or she should act and how we want to be treated by them. So high are our expectations, that many people begin asking medical questions and expecting fairly accurate medical answers from students who have just received notification of their acceptance to medical school.

According to a study done at the University of Chicago, the characteristics of a "normal" or "successful" medical student are orderliness, a high degree of organization, a continual striving for mastery, control, thoroughness, obsessiveness, putting intellect above emotions, security above pleasure, service to others above self-service, and exactitude above fantasy. Medical students work hard for good grades in subjects they care little about, and they hold onto their feelings.[1]

These characteristics, which society expects and which insure success in medical training, may also be a prescription for stress and emotional illness. One writer described the characteristic state of the medical student as:

> "He is anxious while in pre-med training, wondering if he will be able to meet the competition and achieve high enough grades; he is anxious when he applies, feeling that his whole future is about to be decided within a few short weeks or months, and he is anxious when he begins his training. He displays a variety of anxieties during the next four years and except for a certain amount of short-lived relief when he receives his diploma, he is still anxious when he graduates."[2]

In order to define the source of these anxieties, a junior student and I polled a group of peer counselors at the Medical College of Wisconsin and

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A condensation of papers presented at the Conference on the Impaired Physician: Prevention, Intervention, and Rehabilitation, October 14 - 15, 1981, Waukesha, Wisconsin. Edited for publication by Barry Blackwell, MD, Professor and Chairman, Department of Psychiatry (Milwaukee), University of Wisconsin Medical School. Reprint requests to: *Wisconsin Medical Journal*, PO Box 1109, Madison, Wis 53701 (phone: 608/257-6781). Copyright 1982 by the State Medical Society of Wisconsin.

asked them to list the kinds of problems they were hearing from medical students, and the amount of time spent counseling in each category. The top five, from a list of thirteen, were: 1) problems with relationships; 2) loneliness and isolation; 3) workload; 4) self-concept; 5) failing a course or exam anxiety.

Medical training shares many characteristics with other graduate and professional programs, but there are unique components that have a significant impact on the student. The rigidity and the intensity of the training period are unequalled; there are no other educational programs that involve the same total and inflexible commitment of time and energy. The competitiveness of medical school as well as the academic pressures are experienced as stressful by most students; and while most students adapt, others do not.[3]

A significant number find themselves overwhelmed, particularly in the first year. Having been able to learn most or even all of the content of their college courses, they are now faced with an endless array of facts which they believe they must master.[4] It is with difficulty that they learn that perfection is unattainable. For students who have been successful achievers, this is anxiety-provoking, especially in those who fear that they might harm their patients if they do not learn enough.[5]

After the first few exams, a new anxiety develops. Everyone cannot be first and cannot excel. Fears of inadequacy and anxieties about failure may become intense as self-esteem is tied into a comparative ranking system rather than resting with an individual's belief in himself. Many students must rebuild their esteem during the early weeks of medical school—having moved from the top of the heap in college to somewhere along the normal curve in medical school.[6]

The initial months of school may also be disappointing. Courses may not seem to be relevant or supportive of the emerging identity as a physician.[3] Instructors may appear uninterested in medical students. There may be competition between the MDs and the PhDs with a not so subtle undercurrent that the really smart people have doctorates in a specific field. Instructors may seem more concerned about their research interests than in educating future doctors.

In addition, the student needs some time to readjust his personal life; to try to make some time for significant others, and for recreation.

By the second year, a student has generally adapted to medical school or dropped out. Usually his morale has improved because he feels he can make it if he tries hard enough. He is being introduced to patient care and finds his experiences are closer to his pre-entrance expectations of medical training. Also, during the second year the student is exposed to Pathology. This course has been known to produce considerable anxiety and hypochondriasis in students who become convinced that they have the signs and symptoms described in the text.

The third year provides a major change in focus. The emphasis is clinical and the fears shift to—"How well will I do on the wards?",[6] "Do I know enough?", "Will I make the right decisions?", "Can I think things through quickly?". The student must please the attending physicians, the resident, and the patients. Anxiety-provoking issues such as suffering and death must be dealt with. Students must learn detachment without becoming dehumanized.

Since students do come to medicine because they care about people and because they have high degrees of nurturance and commitment and intellectual ability, they are often in conflict about qualities they observe in themselves.[3] They are not always cool under pressure or charming without sleep. They contrast how they are performing with a role ideal that expects them to be ever gentle, comforting, uncomplaining and fully knowledgeable in handling the great responsibilities of life and death. The hazards of a Marcus Welby role stereotype, of endless work, of endless assumption of responsibility as a lifestyle—these hazards are not adequately addressed in the course of medical education.

The final year of medical school is probably the least stressful in terms of the students' feeling that they can handle the material and perform adequately. They are relatively sure that they are going to obtain their MD degrees. Furthermore, they are being treated more like physicians and this enhances their self-esteem.[5] The anxiety-producing factors during this year may take the form of competition for internship positions and indecision over specialty choice. It is not uncommon to see students change their specialty choice because they did not match in the specialty they wanted. As graduation nears, the senior student may become aware that mixed with enthusiasm about graduating, he has strong fears of shedding his student status and taking on more independent responsibilities.

The four-year process has additional burdens and stresses for minorities and women.[7,8] The medical profession in this country is largely white male-oriented so that minority students tend to be looked upon as intruders even when they demonstrate superior talents.

Women face the same stresses as the men but have additional concerns to contend with. They are very concerned as to whether they can simultaneously meet both professional and maternal

responsibilities. They worry about whether they will find a husband supportive of their needs who is willing to share the chores of child-rearing and homemaking. While it is rare for a male medical student to be concerned about what being a doctor will do to his marriage, it is all too common among women students. Women students are often embarrassed at having feelings of tenderness or sadness in public. They are made to feel that it is unprofessional to be visibly upset on a medical or surgical floor when a patient dies, even though it is a sign of health that feelings are more accessible and are expressed more openly.[8] In addition to the expectation that women will not show their tender feelings, they are not expected to express anger and frustration in the same degree that men are permitted to do so.

For men and women both, the practice of medicine demands contrasting skills, a high degree of technical and scientific knowledge, combined with the need for action on the basis of limited information, caretaking and nurturance combined with maximal responsibility and decision-making ability. These conflicting demands impose stress on medical men and women from the beginning of training throughout their professional lives.[3] To recognize the problems is the first step. The next challenge is to develop programs and a commitment to enhance humanistic values in a system already burdened by technological demands.[6] Medical school needs to teach students to talk about feelings. While this might not be curative, it could be highly palliative and often preventative.

The essential elements of a good program of prevention include stability and continuity. The person in charge should not be someone who has any control in any way over the students. The program must have complete confidentiality. There must be an emphasis on prevention and rehabilitation.

The Medical College of Wisconsin has developed a peer counseling program which trains medical students who are in their second, third or fourth year, to counsel any student who requests their help or is referred to them. It is important for physicians to learn that they are not infallible and that it is just as acceptable for them to need help and to seek counseling as any of the patients whom they see in the course of practice. It is equally important for doctors to recognize and treat fellow doctors who present with symptoms indicative of emotional difficulties. Physicians need to be taught, while they are still in medical school, to turn to one another for help and how to give that help.[9]

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2 Physician lifestyle and medical marriages

Barry Blackwell, MD, Milwaukee, Wisconsin
Professor and Chairman, Department of Psychiatry (Milwaukee) University of Wisconsin Medical School

WHATEVER THE STRESSES in a physician's life, their impact is either accentuated or attenuated by that person's preexisting vulnerability or coping capacity. This involves interactions between a physician's lifestyle, personality, and marriage as the major support system.

Medical marriages are not a new area of interest; an article entitled "The Wives of Some Famous Doctors" catalogs the sufferings and supportive role of famous physicians' wives over the ages.[1] Included was William Harvey's wife, Ann, of whom it was noted "as their married life progressed, Ann's happiness became more and more clouded by anxiety for her husband; for, as you know, he used himself as an experimental subject and took terrible risks. He practiced wrestling with the bull the Queen had given him. He pursued and captured two escaped leopards; kept beehives in the conservatory and lived with increasingly frequent attacks of angina, aided if not aggravated by the late effects of self-inoculated syphilis for which he took self-prescribed mercury treatments for a period of three years." This in a capsule form was the life of a doctor-genius' wife.

Osler's wife, Grace, is also discussed; during the time that he was organizing his department at Johns Hopkins, she persuaded him to delay their marriage until after he had finished writing his famous textbook; it is reported that on its completion, he threw the book into her lap and exclaimed, "There, take the damn thing, now what are you going to do with the man?" Less you mistake this for an emancipated view of a wife's role, consider the following quotation from Osler's address entitled "The Student's Life" in which he writes: "What about the wife and babies if you have them? Leave them! Heavy are your responsibilities to yourself, to the profession and to the

public. Your wife will be glad to bear her share in the sacrifice you make."

In 1893 a Mrs Ellen Firebaugh published an article entitled "The Physician's Wife and the Things that Pertain to Her Life."[1] In listing the desirable attributes of a physician's wife, she suggests that "she possess some tact and discretion, and that her bump of curiosity should not be too largely developed. When the doctor comes home, it is more probable that he will enjoy talking about something else than what has preoccupied his mind at the office." Mrs. Firebaugh goes on to note, "The physician husband is so accustomed to having his own way, and his say in the sick room, which is right, that he wants to be the autocrat at the breakfast table, the dinner table, the tea table and the time between tables, which is not right."

If these anecdotes seem quaint, they also illustrate the central theme connecting professional and personal life. This theme persists today, despite the social changes that Howard Rome describes in his article on "The Doctor's Wife."[1] The doctor's office is now seldom his home, telephone answering services have supplanted his wife as a buffer and first aid counselor, accountants provide relief from the burden of office bills and the peer interaction in group practice protects her to some degree from the role of abreactor and the tedium of feigned attention to "interesting cases." But coincident with these ameliorating influences have been other societal changes that serve to heighten tension; women now expect an independent and autonomous role in which they are liberated from the demands of their spouses' professional lives.

Although the historical and anecdotal information suggests that medicine and marriage make a difficult mix, only the data from control studies can reveal how complex the question really is and the degree to which medical marriages differ from others. George Vaillant and his colleagues at Tufts University have studied 47 physicians who graduated over 30 years ago and compared them to 79 socioeconomically matched controls in other occupations with regard to marital breakdown and drug abuse.[2] At first sight, the results appear to support the hypothesis that physicians have significantly more poor marriages (47% compared to 32% of controls) and a higher incidence of drug abuse (36% compared to 22% of controls). However, a close look at the data revealed that these outcomes depend more upon disturbed childhood psychologic status than on choice of medical career. Approximately half of the controls (49%) had good childhood adjustments compared to only one-third (34%) of physicians. When this variable was controlled for, there was no significant difference in frequency of drug abuse or poor marriages.

Several studies have approached the problem from the standpoint of the physician's wife who becomes psychiatrically impaired.[3] Most of the wives were admitted with diagnoses of depression or suicidal preoccupation, but many were also enmeshed in alcohol or drug abuse and the pattern of marital interaction was strikingly similar in the different studies. The stereotypical marriage appears to be between a dependent, histrionic woman with a large need for affection and nurturance who is married to an emotionally detached man. Initially, the phenomenon of "assortative mating" appears to be at play in which women with a need to be "looked after" marry physicians who select patients rather than partners. But the mismatch is also apparent; she speaks the language of emotion while he speaks the language of logic. While he may be the community's greatest need-meeter, the wife does not get the warm available father figure she expected. One survey of physicians' wives[4] found that 95% felt neglected, 53% thought a medical marriage was demanding, and 65% reported that at least some member of the family had received counseling.

The personalities of the physician husbands in these studies appear to confirm Vaillant's findings; the men are described as often professionally competent and successful but also rigid, interpersonally distant, and covertly or overtly controlling. These are the features of the achievement-oriented obsessive-compulsive personality that correlates both with survival in medical school and success in practice. The negative aspects of this personality style sometimes prevent the male physician from obtaining the comfort and solace of marriage as a major support system. The pride in accomplishment and overproduction is coupled with an overdeveloped ability to postpone pleasure. Even though the physician arrives home emotionally drained, he cannot or will not ask for help; this tendency to repress feelings is part of the compulsive personality that is reinforced by the professional need to remain emotionally detached. Used to being in control, the physician is unable to unbend and to seek nurturance himself.

Once the marital relationship begins to deteriorate, the basic flaws that initiate its demise now accelerate it. In order to avoid conflict, the open expression of feelings and what he experiences as excessive demands at home, the physician seeks increasing refuge in practice where the rewards are still present and compatible with his personality needs. In response to her husband's flight into work, the wife may devote herself to community affairs or less adaptively seek solace in the

sick role with multiple somatic complaints that also invite overprescribing and drug abuse. Both partners may seek the affection they need elsewhere and the physician who feels disinclined to sex at home becomes vulnerable to erotic contacts with patients and office staff. Alcohol and drugs are usually only a final step along this path, but once initiated, they impair performance and gratification in both the personal and professional spheres.

In the end, physician marriages break down in the same areas as others; controversies over control, errors in communciation, and unmatched needs for comfort and nurturance. But the personality profiles of the participants and the lifestyle of the physician make a considerable contribution. The deterioration in family life that is apparent at the time addiction becomes apparent is catalogued in the clues listed by Talbott and Benson.[5] These include the physician's withdrawal from family, fights and even child abuse, development of "spousaholism," abnormal or antisocial behavior by the children, sexual problems, and finally assumption of the surrogate role by the spouse or children with the institution of separation or divorce proceedings.

Preventative Aspects. Like everything else in medicine, it is possible to portray too gloomy a prognosis by studying endstage or tertiary pathology and in doing so to miss preventative possibilities. A more hopeful aspect is that four out of five of the same wives who complained so bitterly in the survey quoted above also considered their marriages happy and said that they would marry the same man again.[4] Divorce rates among physicians are actually lower in some studies than many other professional groups and breakdown appears to occur after longer periods of marriage.[6]

A number of suggestions for change have been made; one is that physicians use their compulsivity in a more creative manner to schedule their wives and families into their lives. Simply saying that family and practice are both important is not enough; this may create constant frustration and conflict if urgent practice needs gain priority over routine family plans. Time together must be scheduled and protected.[7]

It would also help if medical students and physicians became more aware of the debit side of their otherwise successful personalities; this might give them permission to seek support and succor from their spouses without delaying their own needs indefinitely. A physician talking to medical students[8] about the dilemma of professional demands and personal needs had the following to say: "Let me change the expression 'personal needs' to 'personal demands' in order to emphasize the imperative quality of self-identity as somehow distinct from professional identity. I suggest that there are two fundamental kinds of personal demands: cultivation of self-respect and support by loved ones. The critical quantitative requirement of these demands is free time. I'm talking about free time to sleep adequately, to stroll along the beach in bare feet, to hear the rustle of pine trees, to play the fiddle or build a cabinet and to learn how to love and grow with loved ones. I am convinced that a physician cannot provide optimal care for patients until as a person he has first learned how to care for loved ones and for himself; on purely intuitive grounds I do not believe the reverse will work at all."

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3 Professional burnout in physicians

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FREUDENBERGER[1] Maslach[2] Hall[3] and Gardner[4] have described burnout in a variety of settings. The metaphoric use of the term "burnout" derives from its literal meaning as failing, a wearing out, and takes its human application in terms of exhaustion occurring from excessive drainage of energy resources. A variety of healthcare professionals were found to share the symptoms which were then also identified as precursors to alcohol and drug abuse. These individuals experienced diminished levels of efficiency, initiative, interest and the capacity to cope with stress.

"Physical signs and symptoms include: 1) feelings of exhaustion and fatigue and a sensation of being physically run down; 2) frequent headaches and gastrointestinal disturbances which may be accompanied by 3) weight loss; 4) sleeplessness; 5) depression, and 6) shortness of breath. Behavioral symptoms include: 1) lability of mood; 2) blunting of affect; 3) quickness to anger with increased irritability; 4) diminished frustra-

tion tolerance; 5) suspiciousness, at times bordering on paranoia; 6) feelings of helplessness; and 7) increased levels of risk-taking. These physical and behavioral symptoms frequently result in attempts to self-medicate, using such readily available agents as tranquilizers, barbituates, narcotics and alcohol, all of which may lead to addiction."

The insidious progression of the process may be realized more graphically by labelling successive stages: 1) The Honeymoon—enthusiasm and satisfaction; 2) Fuel Shortage—fatigue, sleep disturbances, possibly some escapist drinking or shopping binges; 3) Chronic Symptoms—exhaustion, physical illness, acute anger and depression; 4) Crisis—illness that may become incapacitating, deep pessimism, self-doubt, self-preoccupation; 5) Hitting the Wall—career, and even life, threatened.

Although the formal studies to date identify burnout occurrence primarily in organizational contexts, the syndrome is probably more extensive and pervasive occurring in all levels and settings where physicians work and train—from medical school to retirement, from hospital and clinic to the private office, from office to home.

Among physicians I have observed in burnout, prominent personal qualities include longstanding reticence over sharing of feelings, a general limitation of direct communications, and definite compulsive personality traits. The very qualities which supported their achievements become burdensome, counterproductive and anxiety-producing and lead to chasms and rigidities in interpersonal relations at all levels of the physician's existence. Communication channels break down, meanings become lost, supportive influences become hidden. Retreat into self becomes inevitable. This is heightened by additional pressures imposed by the natural transition through the developmental life stages of the physician, particularly the ubiquitous "mid-life crisis." Dependency needs may be either denied, leading to rigidity of personality, or overzealously pursued, as in extramarital adventures.

The compulsive's lack of flexibility renders him or her less fluid in performing all these life tasks competently. The marital arena frequently is most affected by this shock wave. The physician is ripe for complications: drug or alcohol abuse, depression or other disability.

The physician, having cast himself or herself into the special role of healer, carries within themselves the potential for either underreacting or overreacting to the continuing stresses of their work, whether it be as a private clinician or in a team setting. The latter includes intensive care units of various types. These are often characterized by extremely high and unremitting stress and frequently encountered limited successes or outright failures.

When burnout occurs within an organized setting, a variety of contributing factors have been identified:[1,3,4]

1) high responsibility, disproportionate to the degree of authority allocated; 2) continued, unabated stress of work; 3) insufficient recognition of the individual's worth; 4) inflexibility in organizational structure; 5) too little avenues for personal contact or communication; 6) insufficient feedback per se; 7) ambiguous lines of authority; 8) insufficient acknowledgement of the prime mission, and its consequences for all personnel; 9) excessive performance demands, with unremitting induction of guilt; 10) personality limitations throughout the network, insufficiently monitored, confronted, or channeled.

To prevent and detect burnout, there are a number of steps that may be taken:

1. Acknowledgment, by responsible leaders in all walks of medical life, of the fragile human being who can get 'caught up in the machine' of modern life. This special respect for the individual could lead to more humanistic planning of medical facilities and functions.

2. Recognition of the value of the small group as a powerful resource for human reinforcement, growth, corrective modification, security, learning, clarification and creativeness.[5] This instrument can take many forms, depending upon the need and the setting, and include the following: peer support groups among medical students, residents, faculty, clinical unit personnel, practitioners.

3. At organizational levels (*eg,* intensive care units) steps to provide improved sharing, clarity, contact, accessibility and structural delineation, if necessary with outside consultation from an organizationally-oriented psychotherapist.

4. Early recognition of the burnout process by self, family, colleagues, superiors. All too often, patients being tended are the first to signal alarm, a sign of malignant progression.

5. Establishing a positive evaluation system for early recognition and reporting as part of a total program of enablement and strengthening. This is to be differentiated from a punitive, judgmental or authoritarian approach.

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4 Chemical dependency in physicians

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CHEMICAL DEPENDENCY is the condition in which individuals have a need or desire to change the way they feel with mood-altering drugs on an ongoing basis. This use is associated with the development of strong psychological dependence and tolerance to the drug as a minimum. In addition, there are always *ongoing* problems associated with this dependency in the physical, mental, social, or vocational areas of the person's life.

I. TYPES OF MOOD-ALTERING DRUGS

A. ***Depressants***

1. *Sedatives*
   - (a) alcohol
   - (b) barbiturates
   - (c) nonbarbiturate sedative hypnotics
   - (d) benzodiazepines (Valium®, Librium®, etc)
   - (e) chloral hydrate
   - (f) ether
   - (g) paraldehyde
   - (h) cannabis

2. *Narcotics* (opiates/opioids)
   - (a) opium
   - (b) camphorated tincture of opium (Paregoric)
   - (c) morphine
   - (d) heroin
   - (e) Dilaudid®
   - (f) codeine
   - (g) ocycodone
   - (h) Demerol®
   - (i) Talwin®
   - (j) Stadol®
   - (k) other opioids

B. ***Stimulants***

1. *Amphetamines*
2. *Cocaine*
3. *Hallucinogens*

The overwhelming majority of chemical-dependent physicians are involved with depressant drugs. These drugs are characterized by the fact that they are all addicting, and there may be cross-addiction between members of the sedative group. They are all capable of inducing tolerance and cross-tolerance within their own group. There is not cross-tolerance between sedatives and narcotics. Psychologically, however, physicians may substitute a sedative drug, particularly alcohol, for a narcotic should that drug not be available to them, and alcoholics have been known to substitute other sedative drugs or to use other sedative drugs simultaneously. Alcoholics may also develop secondary narcotic addiction.

A review of the first 40 doctors treated in the De Paul Impaired Physician Program broke down into:

1. Primary alcoholics
2. Primary alcoholics with dependence on other mood-altering drugs
3. Primary narcotic addiction
4. Primary narcotic addiction with secondary dependence on other drugs.

Less than 5% were involved with stimulants on any kind of an ongoing basis. The primary-secondary dichotomy is based on the chronologic development of the addiction; *ie,* which came first?

II. HOW DO YOU GET CHEMICAL DEPENDENCY?

A. ***Development of Chemical Dependency***

(1) Development of chemical dependency begins with the experimentation, by an otherwise chemically-naive individual, with one or more mood-altering drugs. The reasons commonly given for the repetition of this experience are as follows:

(a) *"I like getting high."* The feeling of detachment and euphoria is particularly appealing to some individuals, and results in repetition of the experience, with continued reinforcement of the pleasurable stimulus of "getting high."

(b) *Disinhibiting effect.* Many individuals claim that alcohol and other mood-altering drugs allow them to socialize in a more normal way. This may be a very strong stimulus to repeat the drug effect in those individuals who are shy or otherwise incompletely socialized. This has been called the "normalizing factor" by some authors.

(c) *Sedative/tranquilizer effects.* Alcohol is the world's largest and best-selling tranquilizer, even though diazepam (Valium®) may be giving it a bit of a push. This is surprising, in view of the dual effect of sedative drugs inducing short-term sedation and longer-term anxiety effects. Many physicians have indicated that several strong highballs or cocktails at the end of a stressful day, at least in the beginning, were effective in relieving tension and anxiety. This kind of drinking has been called "stress relief" drinking and is a classical example of using alcohol as a drug rather than as a social lubricant.

It is likely that while any given individual may point to one of these effects as the principal reason for continuing to use alcohol or other mood-al-

tering drugs, all of these effects contribute reinforcement to continued use of these substances.

Stress-relief drinking is analogous to escape drinking. A more challenging set of circumstances relates to the use of alcohol or other mood-altering drugs to self-medicate underlying psychiatric disease. This is encountered in a wide variety of psychiatric disorders, but in physicians it is most often seen in bipolar affective disorder, more often in the manic phase, but is also known to occur in the depressive phase. Unipolar depression, neurotic depression, anti-social personality are examples of additional problems which may result in secondary chemical dependency. Many individuals suffering from these disorders find temporary relief by self-medicating with other mood-altering substances. An unknown percentage of these individuals become habituated and finally develop dependency syndromes on these substances. This naturally leads to the classification of chemical dependency into primary and secondary types. This dichotomy has been criticized on the basis that once an individual becomes dependent on alcohol or other drugs, it matters little what initiated the drug use, inasmuch as the addiction is self-perpetuating. The primary-secondary dichotomy is extremely important, in this author's opinion, because the development of an adequate, long-term treatment plan and rehabilitation program requires knowledge of these underlying factors, so that with abstinence the proper psychiatric treatment may be applied.

In our experience approximately 20% of physicians have underlying major psychiatric syndromes or personality disorders which require fairly intense psychiatric care in addition to the multi-disciplinary treatment of their chemical dependency. This is an area which requires close cooperation on the part of the addiction centers and the psychiatric profession, so that a proper team approach to the management of these complex disorders can be successful. In the differential diagnosis of chemical dependency, one should always inquire as to the pre-alcoholic or drug-dependency personality of the patient; *ie,* the presence or absence of significant psychiatric pathology prior to the onset of chemical dependency. If so, both conditions must be treated in order to enhance the probability of success.

The major problem with the primary-secondary dichotomy is that the longer secondary chemical dependency exists, the more the distinction between the two becomes blurred—secondary becomes primary—but knowledge of previous emotional problems is essential for long-term rehabilitation.

The diagnosis of depression (unspecified) is often made in the early drug-free period or during periods characterized by intoxication withdrawal phenomena. Patients should be chemically free and well past the intoxication phase in order to assure more accurate diagnosis. The classical example of this problem relates to the sadness (depression) associated with acute and chronic alcohol abuse. This mood alteration has been shown to be due to alcohol toxicity,[1] and will usually clear with five to seven days of abstinence. Deteriorating life problems will add to this. This sad mood should not be confused with affective disorder.[2] There is no evidence that tricyclic antidepressants will be helpful in this condition, and their use for a self-limiting condition psychologically reinforces the patient's belief that there must be a chemical solution for every bad feeling. This type of sadness is often seen following periods of intoxication with other drugs.

The increasing reliance on mood-altering drugs, for whatever reason, results in habituation to these substances; *ie,* strong psychological dependence, which gradually results in the compulsive use of these substances. As the drug use becomes more frequent, tolerance to the substance occurs, requiring escalation of the dose in order to attempt to achieve the original positive effect. If the pattern of drug usage is on a daily basis and is of a sufficient amount for a long enough period, physical dependence may occur. Physical dependence then is a function of the pattern and quantity of drug usage. It requires daily usage of those drugs which have a short half-life in order to achieve physical dependency. Regular use, at the proper interval, is required for those substances, such as diazepam, with a longer half-life. While these basic functions of addiction are in the process of development, the patient begins to experience impaired control over the use of these substances, so that on any given occasion the patient cannot predict with certainty when he will stop using the drug once its use has begun. As the overall process intensifies quantitatively, loss of control becomes more frequent. This is associated with beginning development of ongoing problems in one or more areas of an individual's life.

III. DIAGNOSIS

Physicians get chemical dependency much in the same way as anyone else. However, doctors characteristically underestimate the effects that drugs have on them.[3] Therefore, they will use drugs on themselves that they would not consider prescribing for their patients; *eg,* a common practice is for physicians who are having problems with insomnia to inject, often intravenously,

meperidine or other narcotic drug. They believe that they can stop using the drug any time they wish, in view of their great knowledge of clinical pharmacology, and the like. Such a delusional system permits a very rapid development of addiction to narcotics. Dependency on alcohol and other sedative drugs occurs more slowly, and it is basically associated with the same defenses as that seen in the general population.

The diagnosis of chemical dependency should not rest solely on the amount or frequency of drug use. Denial is a cardinal symptom of this disorder, and physicians have particularly intense denial which, on the surface, is most convincing. As pointed out by Talbott,[4] it is much more productive to examine carefully the physician's lifestyle and, particularly, to look for departures from the historically normal behavior of the involved physician. The disease of chemical dependency makes its presence felt first in the family, when the physician may withdraw from family activities in which he usually participates. There may be prolonged absences from the home, and erratic behavior characterized by wide mood swings; hostile, belligerent relationships with the spouse and children and, indeed, this may progress at a variable rate to separation or divorce. Commonly, the physician during the development of chemical dependency may be involved in extramarital affairs. In addition, the physician is found to be withdrawing from his friends and peers. His community activities are severely curtailed. One may obtain a history of frequent job changes, with or without a history of multiple hospitalizations, often for vague diagnoses. The physician, who ordinarily presented a neat and meticulous appearance, may now appear in public poorly dressed, and with poor personal hygiene.

Later in the developmental process, there are problems at the office, relating to arriving late and leaving early. The physician may, for the first time, be hostile and unkind to patients who frustrate him and, finally, in the very late stages, the physician may appear at the hospital or office under the influence of drugs. He may be difficult to arouse for an emergency at night, and may demonstrate bizarre behavior with respect to hospital staff. Poor handwriting, while a characteristic of many nonchemically-dependent physicians, often shows notable change for the worse in physicians impaired by alcoholism or other drug addiction. There is an overall breakdown in the general discipline of the physician's practice, both in and out of the hospital. Incomplete medical records accumulate to the point where medical staff and administration are required to invoke discipline, often suspension of hospital privileges.[5]

Documentation of these changes in lifestyle and personality are readily obtained from individuals such as the local pharmacist, hospital and office nursing personnel, colleagues, and especially, emergency room nurses.

Intervention may be at any point in the natural history of the disorder. The earlier the better. Confrontation may be by family, close colleagues, medical society impaired physician programs, hospital impaired physician committees, or other hospital administrative committees. Such confrontations need to be pursued with vigor, and a variety of community resources need to be involved in a successful intervention.

IV. TREATMENT

Treatment of physicians with chemical dependency should be in a multidisciplinary treatment center which has the ability to deal broadly with the addiction. In our opinion outpatient treatment of addiction in physicians is not a viable option. Physicians have a great deal of trouble accepting the role of patient, and in an outpatient setting they have a variety of built-in excuses for not following through with the treatment. An initial inpatient phase of several weeks, in which a physician is able to gain enough insight into his problem to make a commitment to long-term treatment, is necessary. The multidisciplinary approach utilizes an attending physician, consulting psychologist and psychiatrist, certified alcoholism counselor, clergy, and occupational therapist. Treatment modalities include group therapy, individual counseling, introduction to Alcoholics Anonymous, occupational therapy, recreational therapy, and involvement of family members in the treatment process.

It has been our experience that a four-week program of this type is adequate for 85% of physicians we have treated. However, 15% have required additional residential inpatient treatment, usually for a period of four to six months. These patients generally include those who have had a significant relapse and who need environmental control, as well as physicians with certain psychiatric disorders and addiction. Following the inpatient phase of treatment, a two-year monitored outpatient program is desirable. This program utilizes individual and group counseling, specialized family therapy, urine screening for alcohol and other drugs on a random, witnessed basis, and further involvement of the physician in the community and physician Alcoholics Anonymous groups. It is our experience that about one-third of the physicians in such a program will relapse to the use of alcohol and other drugs. Relapse is a serious complication of the recovery process and needs to be diagnosed and treated promptly.

We have divided relapse into "brief" and "significant." Brief relapse is defined as a return to alcohol or other drug use for a period of less than one month with no major life problems. A significant relapse refers to a return to alcohol and drug use for more than a month, with the occurrence of life problems as a result of the return to drinking or drug use. Significant relapses tend to occur earlier in the post-hospital phase, and tend to have serious prognostic indications if not dealt with most aggressively. The overall rate of recovery of physicians in such a program should be in the neighborhood of 80%.

A common cause of failure is substitutive addiction. The treatment philosophy must be one of total abstinence from all mood-altering drugs, unless there is a most compelling medical reason for such use. We have found that narcotic addicts frequently develop secondary alcoholism in the so-called recovery period, while alcoholics most commonly substitute a solid sedative, such as diazepam. The occurrence of substitutive addiction will, with time, see the re-emergence of the old problems and, most often, a return to the use of the patient's initial drug of choice.

V. RECOVERY PROCESS

The greatest struggle in the first year of recovery is to remain free of alcohol and other mood-altering drugs. Relapses occur in individuals who, for a variety of reasons, fail to completely "surrender." Health care professionals need to be aware that any relapse needs to be diagnosed and treated early. The longer the drinking or drug use is allowed to continue, and the more life problems that accumulate, the more difficult it is to motivate a patient to return to the sobriety program. Individuals who relapse need to have their long-term treatment plan reviewed by appropriate specialists in the field of chemical dependency. Some of the more important items to be assessed at such a relapse are:

1. Attempt should be made to define what triggered the drinking.
2. Was the patient in compliance with all of the conditions of his previous treatment plan?
3. What is the status of the co-alcoholic or co-addict? Is this person receiving help?
4. Has the person developed a substitute addiction; *ie,* has the alcoholic substituted diazepam (Valium®) for alcohol, or has the narcotic addict substituted alcohol for narcotics? Are multiple drug dependencies present?
5. Is the patient actively involved in Alcoholics Anonymous or Narcotics Anonymous? Does he have a sponsor? How many meetings is he attending?
6. Is the patient now manifesting underlying signs of a major psychiatric condition which was not apparent at the time of original treatment?
7. Any other factors which may relate to the individual patient.

Patients with brief relapses rarely need to return to an inpatient treatment program and are well managed on an outpatient basis. Patients with significant relapses often require inpatient treatment for environmental control and intensity of program.

A common factor contributing to relapse in a recurring fashion is alcoholic brain disease. These patients are often not able to conceptualize a cognitively oriented program and, consequently, cannot respond positively to such treatment. It is important in the initial treatment process to evaluate alcoholics for organicity, and when present, to prescribe treatment which is in keeping with the intellectual capacities of the patient. Many of these individuals require extended care in recovery homes or medically-oriented inpatient extended care programs. Outstanding results are often seen if these patients can remain alcohol- or drug-free for a significant period while being in a supportive, rehabilitative environment with good nutrition.

SUMMARY. Chemical dependency is an occupational hazard in the practice of medicine which probably affects one in eight physicians at some time or other in the course of their professional careers.[6] Awareness of the syndrome of chemical dependency, and the utilization of family, professional, and community resources permits the early diagnosis and successful treatment of the overwhelming majority of these physicians.

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5 Psychiatric impairment and the disabled physician

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PHYSICIANS FUNCTION in an environment of protracted chronic stress. Most individuals in the healthcare professions have high expectations of themselves regarding their ability to work with and to help others. Further, society's expectations of physicians are often unrealistic. The standards for the physician as spouse, parent, employer, colleague, and socially involved citizen are higher than those for other community members. George Vaillant[1] identified three symptoms suggestive of psychologic vulnerability in physicians; namely, bad marriages, drug abuse, and the tendency to use psychotherapy. These symptoms are frequently dismissed as the "occupational hazards" of medical practice; yet when compared with their socioeconomic peers, it becomes apparent that only a minority of physicians experienced these difficulties and that for most, their vulnerability antedated their entrance into medicine. Only physicians with unstable and fragmented childhoods and adolescent adjustments appear vulnerable to these kinds of occupational hazards.

Many studies besides Vaillant's have demonstrated that impaired physicians are more likely to exhibit the traits of dependency, pessimism, passivity, guilt, self-doubt, and feelings of inferiority. Developmental vicissitudes play an important role in the genesis of future psychopathology. Many disabled physicians have had mothers and fathers who were over-protective with normal separation-individuation processes arrested and obscured by "constructive" overcompliance in the form of high academic achievement.

Modlin and Montes's[2] study of 25 narcotic-addicted physicians showed these individuals to have moderately severe progressive personality disorganization with many of the stigma of the oral dependent character. The physicians studied tended to have had difficult childhoods and adolescences. As adults, few had stable marriages. In another study,[3] 50 percent of patients younger than 40 years showed borderline personality organization with evidence of impulsiveness, unstable and intense personal relationships, affective instability and identity disturbance while only around 12 percent of patients older than 40 years showed borderline personality organization. Physicians with higher level personality organization were much more likely to use alcohol alone rather than alcohol with other drugs or other drugs alone.

Depression of some magnitude is present in at least two kinds of disabled physicians. In addition to the personality problems alluded to above, this outcome can also be related to the characterological tendencies of physicians in situations of conflict to suppress and/or repress their anger rather than strike out against the environment. Not expressing anger is not maladaptive per se but if healthy outlets for frustration remain inaccessible because of characterologic proscriptions, the likelihood of a major affective disorder increases greatly. Dependency is a two-way street. The excessively dependent doctor attracts more than his or her fair share of dependent patients which can lead to readily becoming overburdened. Those physicians choosing careers in primary care specialties may be somewhat more psychologically vulnerable to such problems if they elect to assume direct patient care as a way of trying to give to others the care they themselves did not receive as a child. The depressive reaction is also more likely to be precipitated by an obsessive behavioral style that no longer successfully wards off prohibited and denied dependency feelings leading to a sense of loss of control and to impaired self-esteem. Compulsive traits with behavioral manifestations of perfectionism, rigidity and overconscientiousness have been well-described by Dr Harold Lief.[4] Masochism manifested by a flight into work that results in a life essentially without pleasure is a trait that appears to me to be very frequent in the personality organization of the depressed physician.

Ross[5] has emphasized the tragic outcome of depression among physicians. In the United States suicide accounts for more physician deaths than automobile accidents, plane crashes, drownings, and homicides combined. Among medical students suicide is the second most common cause of death. At least 100 and perhaps up to 300 physicians take their lives each year. As indicated, depression is an outgrowth of characterologic qualities that have proven adaptive for most physicians.

Treatment. Pressure usually must be applied to engage the impaired physician in treatment whether the primary problem is drug or alcohol addiction or psychiatric illness. Most deny the need for hospitalization and deny that their problem is noticeably impairing their ability to practice. Talbott[6] noted that the disabled physician was almost unable to reach out for help no matter how perilous his or her situation. Most are forced to seek treatment by external pressures.

The chief motivating factor is job jeopardy usually as a result of confrontation by colleagues in a group practice and threat of suspension of hospital privileges or medical license under review by the state medical board. A spouse initiating divorce proceedings or other family pressure can be a strong motivating force.

In addition to developmental and characterologic considerations discussed earlier, it is important to consider the increasingly accepted view that mental illness consists of poorly functioning brain regulatory mechanisms that produce distressing symptoms, upsetting ineffective actions, and some degree of impairment. Adoption studies, responses to medication, and studies of brain chemistry point to a biological component in mental illnesses and to heredity as a large contributing factor. Psychological treatment is necessary but in major disturbances, which are present in over one-half of disabled physicians, medication may be indicated on a time-limited, continuation, or maintenance basis. It may also play an essential role in moving the patient to a point where psychotherapy can begin; that is, in reducing thought distortion, emotional malfunctioning or inappropriate behavior sufficiently so that the patient can benefit from talking about the difficulties and conflicts that have led to crippling illness. Physicians are also "much more human than anything else" so that it is important to realize they are susceptible to conflicts surrounding sexual, aggressive, and dependency wishes in direct proportion to the limitations their developmental milieu and hereditary endowment have placed upon them.

Reports indicate that with constant surveillance and tightly structured aftercare programs, around 60% to 70% of physicians can return to full practice responsibilities. The criteria for successful treatment are usually abstinence and a return to effective job functioning with the physician not experiencing repeated episodes of guilt, anxiety, poor self-esteem, and either more drug or alcohol use, or a recrudescence of the primary psychiatric syndrome.

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6 The impaired elderly physician

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THE IMPAIRED PHYSICIAN has been the subject of a number of national conferences in the past few years.[1,2,3] Some elderly physicians become impaired because of physical illnesses, such as heart disease, cancer, stroke, and the like, but they seldom require any special management in terms of maintaining their level of medical care competency. However, in the case of early senility or dementia, we are dealing exclusively with the aged physician and with an illness which at the present time has very little rehabilitation potential. Dementia in physicians has received little emphasis and is not to be confused with the broader issue of mentally competent physicians who may be incompetent to practice medicine because of failure to keep up with advancing knowledge in the field of medicine.

The normal changes of aging of the central nervous system affect intelligence, memory, and learning ability.[4] There are longitudinal changes that occur in intelligence testing with age. Starting at about age 50 there begins to be a very modest decrease in intelligence test values which becomes progressively more marked in the older age groups. The appropriateness of the tests for elderly subjects is controversial and the meaning of intelligence as revealed by such testing is not clear. But most psychologists agree that these changes with age are significant and meaningful.

Memory also becomes defective with age. Younger people recall information and knowledge more easily than older people, while the process of recognition is relatively unaffected by age. Lastly, there is a marked increase in the number of errors in learning tests made by the elderly compared with younger individuals. However, if learning is not related to the speed of acquiring information, then there is a relatively modest increase in the number of errors made by older compared to younger subjects.

In summary, the changes resulting from normal aging are a modest decrease in intelligence, a decrease in memory, primarily in recall, and a decrease in rapid learning ability. But these normal changes of the aging of the central nervous system do not necessarily incapacitate a person intellectually. Many practicing physicians over age 65 continue to function at an intellectual level that does not impair their competence as physicians.

The problem of early dementia is different; it in-

volves a disease state rather than the normal changes of aging. About two-thirds of the cases of dementia in the elderly are now felt to be due to a process characterized by marked neuronal dropout and by characteristic biochemical abnormalities, such as a decrease in choline acetyltransferase, and pathological findings, such as neurofibrillary tangles and neuritic plaques.[5] This condition is now called Alzheimer's disease, since it is pathologically the same as presenile dementia, exclusively called Alzheimer's disease in the past. About 20% of dementia is due to arteriosclerosis. This type of dementia is frequently called multi-infarct dementia since it is associated with infarctions of the brain.

Dementia is characterized by major cognitive defects, of which the most striking is a progressive defect in memory. It is not the same as the normal senescent memory defect but is associated with confusion, disorientation as to time and place and defects in judgment and abstract thinking. In addition to these intellectual factors, there are emotional disturbances in dementia which are a major aspect of the illness. Demented patients may suffer from agitation, hostility, or marked paranoid reactions. Some patients develop flattening of their affect and are simple or childlike. Lastly, patients with dementia, particularly those with far-advanced dementia, have disturbances of gait, weight loss, speech defects, incontinence of bladder and bowel and neurologic signs, such as positive grasp, palmo-mental and snout reflexes.

In addition to Alzheimer's disease and arteriosclerotic dementia, there are other types of dementia that may be treatable, such as that associated with severe depression, sometimes called pseudo-dementia. Patients with severe depression have memory loss, confusion, and even disorientation. They may have weight loss and agitation. Even the most experienced geriatric psychiatrist finds it difficult to differentiate between severe depression and senile dementia in some elderly patients. Moreover, some patients with true senile dementia will have a superimposed depression. Such patients may be treated with antidepressant agents to see if the intellectual function improves, or at least to see if the affective disorder accompanying the dementia improves.

Other potentially treatable causes of dementia are myxedema and serum B_{12} deficiency. It also is useful to stop all unnecessary medications when a physician first sees an elderly patient. There are many elderly patients who take minor or major tranquilizers that result in mild-to-moderate cognitive defects that could be mistaken for senile dementia.

There is little question that severe dementia among physicians practicing medicine is not a problem, but whether early dementia characterized by moderate cognitive defects and episodes of occasional confusion and agitation is present in some practicing physicians is unknown.

In Wisconsin the statistics for the number of physicians over age 75 practicing are not available, but 7.6% (485 physicians) are over age 64. As a rule senile dementia starts rather late in life, usually in the 70s or 80s, and mild dementia is present in about 10% of the elderly general population. It is not known if any of these 485 licensed physicians have mild-to-moderate dementia with impaired cognitive function, poor judgment, and occasional mild confusion, but there is reason to hope that physicians might have less dementia than the general population. Many psychiatrists and workers in the field of dementia feel that isolation is a contributing factor to the development of dementia, and physicians as a group tend not to be isolated. Certainly those physicians who continue to practice after age 65 keep their brains and their bodies working and do not suffer from isolation.

Information about dementia in physicians is very fragmentary.[7,8] Of 200 physicians admitted to an Ontario sanitarium for psychiatric problems over a 17-year period, only five were diagnosed as having organic brain syndrome, and of 93 physicians admitted to the psychiatric unit of the Mayo Clinic, only six had organic brain syndrome. Of 356 physicians investigated by the Virginia State Board of Medicine, 2.3% were diagnosed as senile.

It is well-known that at least one-half of nursing home patients have significant dementia. A recent survey of nursing homes in Milwaukee County indicated that there were five physicians presently in nursing homes, approximately 1% of living physicians over age 65 in the county. Since about 5% of the elderly population is institutionalized, 1% is a low figure; but it may be due to economic, cultural, and/or health reasons.

Finally, 304 physicians were investigated by the Wisconsin Medical Examining Board during a three-year period, 1976-1979.[6] Twelve percent of physicians over age 64 were investigated, whereas only 5% of all practicing physicians were investigated. Does this information indicate a problem with elderly physicians, and if so, is it early dementia? Much more information is needed before any conclusions can be drawn.

If there is a problem of early dementia in some elderly physicians, what is the solution? Certainly the impaired cognitive function and defective judgment of dementia is not compatible with acceptable standards of patient care. One solution is effective impaired physician committees in hospitals and medical societies. Another might be a required examination of physicians measuring knowledge, ability, and clinical judgment for relicensure, a complex and unpopular solution. At the present time we need to be more

aware of the problem and collect more information for better solutions.

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7 The role of professional peers and hospital staff

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ABOUT FOUR YEARS ago, a growing awareness of the magnitude of the problem and an increasing perception of the legal responsibilities on the part of medical staff officers, administrators, and hospital trustees, led to the formulation of a formal and structured Impaired Physician Program at St Luke's Hospital in Milwaukee. From the outset, it was intended to focus on rehabilitation rather than punishment. It was felt that such a program could not only serve to provide moral support and encouragement from interested colleagues but also could provide documentation of responsible action on the part of staff and physician alike if ever a legal challenge arose.

When any staff physician comes to attention as a possible impaired physician, we invite him/her to a frank discussion of the matter with a small committee composed of medical staff president, president-elect, chief of the department involved, and the chief of a separate, but related, department. This subcommittee reports quarterly to the parent Executive Committee in closed session, without minutes. If our concerns seem justified, we require an evaluation by an institution such as DePaul, Mayo Clinic, or the Atlanta facility. If judgment is that the physician is impaired by virtue of drug or alcohol abuse, then he is given a leave of absence until he has completed a 30 to 90 day inpatient detoxification. This is then followed by outpatient care that includes group therapy and frequent, random spot-checks such as urinalysis to determine continued compliance. When we have been notified in writing that the physician has completed the program of detoxification successfully, he is re-admitted to practice dependent upon the periodic receipt of reports of continued success from the monitoring institution, usually submitted on a quarterly basis. Two years of followup is required, although this has been extended in individual cases. The physician signs a formal agreement that permits us to receive the reports, spot-check him with appropriate laboratory tests or require him to report to the monitoring institution. The impaired physician knows that this information is confined to a small number of persons, that it is kept in a file to which only the chief-of-staff or the administrator has access.

In four years we have identified 15 impaired physicians from a staff of 425, an incidence of 3.5%. Approximately half were problems of drug abuse, one quarter alcohol abuse, and one quarter were both. No instance of senility or physical disability reached the level of this committee, all having been resolved at the departmental level. Impaired physicians have come to our attention voluntarily, through the pressures exerted by family members, through the observations of nurses and pharmacists, and on occasion, in response to the pressures exerted by partners in practice or colleagues. In almost every instance we have encountered frankness and cooperation, and the short-term success of the program has been truly astounding. Of the 15 physicians, 13 have achieved apparent complete success and are actively practicing today. In most instances the majority of their colleagues are unaware that there has been any irregularity for we are very "security conscious" and wish to keep these matters from becoming the subject of corridor conversation. One physician has lapsed and returned for further therapy and another has voluntarily withdrawn and left the community. We are not so naive as to believe that this high success ratio will continue—however, in the event of relapse, our motivation will remain that of support and rehabilitation.

In a small number we encounter resistance and the program falters. There are those who deny that they qualify as impaired physicians even after having undergone detoxification, insisting that they did so in order to appease family members or colleagues and not because they really needed it. There are those who insist "I'll handle it myself" and decline any offer of help. And, there are those who refuse on the basis that acknowledgment of the problem will serve to stamp them forever as "undesirable." They feel that some of their colleagues will consider drug or alcohol abuse to be in the same category as leprosy or

syphilis. Moreover, public knowledge of their problem could be even more disastrous. This latter group objects to the existence of a file even though it may contain only the certification of their fitness to practice. At times, persuasion fails and then the medical society program can be of real assistance by taking it out of the home arena. Sometimes, everything fails, and a firm stand is necessary. Threats of legal action cannot be accepted as a basis for inaction on the part of the medical staff.

Based upon the limited sample, I cannot provide a valid personality profile of the drug or alcohol dependent physician—they are heterogenous in age, sex, motivation, or type of medical practice. But a word about impairment due to senility: The common denominators here are age, the desire to continue to work at something seen as overwhelmingly desirable and enjoyable, and the inability to recognize the subtle development of faulty judgment. While this group may have posed a serious problem at one time, I have found that today's elder physician is quite ready to accept the advice of peers, and the problem is resolved through the chief of the department. Physical disability has also been handled at departmental level. If possible, some sort of niche must be maintained for these physicians as more than their pride is at stake.

Hospital-based programs are an important contribution to successful rehabilitation because they bring to bear the aid and encouragement of friends and colleagues; the hospital and staff know of the problem but certify fitness to practice, and they reassure the public that we do not look the other way when our house is in disarray. The most enthusiastic supporters of the Impaired Physician Program are the impaired physicians themselves.□

8 Role of hospital administrator

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PATIENTS AND employees are the ones who are primarily affected by an impaired physician's disruptive behavior, and the administrator has the responsibility of assuring that corrective action is undertaken. The *Darling* case, in which the court held that the hospital could be liable for the negligence of physicians, makes the hospital's responsibility for the actions of the medical staff very clear. The administrator is responsible for assuring quality patient care, protecting hospital employees, and providing an effective and efficient work environment. To protect these interests, the administrator must establish mechanisms to deal with the impaired physician, and assure that these mechanisms are effective.

The issues involved with physician impairment are multi-faceted. A hypothetical case will illustrate the complexities and identify the role of the administrator.

Doctor Smith was a prominent member of the community and a highly respected surgeon who had been on the hospital's medical staff for 27 years. Doctor Smith had devoted much of his life to the hospital, was extremely popular, and his political ties were strong.

Concern about Doctor Smith's changing behavior was brought to the administrator's attention by the director of nursing. His written orders were becoming increasingly difficult to understand, and when contacted for clarification, Doctor Smith would respond belligerently. A pattern of behavior, very different from the past, was evident.

The situation with Doctor Smith became more acute when the director of nursing reported that staff nurses considered some of the doctor's orders to be inappropriate, and that he would periodically make rounds late at night.

The administrator evaluated the situation and considered the following questions:

1. Did the physician's mental or physical condition pose any immediate danger to his patients?
2. To what extent did his unpredictable behavior interfere with operations on the nursing units?
3. Does the evidence suggest a recurrent pattern?
4. What might be the nature and cause of the physician's impairment?
5. What are the alternatives for corrective action?

After concluding that there were sufficient grounds for concern, the administrator met with the Chief of the Department of Surgery and the Chief-of-Staff and it was agreed that the Chief of Surgery would look into the matter as quickly and discreetly as possible.

In the meantime, a serious mishap occurred. Due to a mistake on Doctor Smith's part, which was also undetected by nursing staff, a serious medication error occurred and placed a patient in jeopardy. Suggestions were made that the error was not an isolated instance, and that similar incidents had occurred but had been covered up. Reflecting on these new developments, the administrator then considered the following:

1. Did the evidence indicate a critical decline in performance and quality of care?
2. If Doctor Smith continued to practice, would the welfare of his patients be in immediate danger?

3. Have events progressed to the point where it would be impossible to deal with the situation discreetly?
4. What are the alternative courses of action?

It was then agreed that the Chief of Surgery and Chief-of-Staff would meet with Doctor Smith, to discuss the problem and identify a course of action.

As a result of this discussion, the cause of Doctor Smith's behavioral and mental problems was uncovered. For the past year Doctor Smith had been ill and was under treatment with medication that began to affect his behavior, personality, and professional judgment.

The case illustrates only one form that physician impairment might take. One can easily encounter situations regarding substance abuse, mental illness, or somatic disease. However, no matter what the cause of the impairment, the administrator must exercise responsibility by assuring that corrective action is taken.

The first step in dealing with an impaired physician is to insure that there are adequate mechanisms to document the situation by identifying evidence of the physician's impairment. The available data must then be evaluated to determine the appropriate course of action.

It is also important to recognize that if the impaired physician is well-liked and respected, house staff, colleagues, or nurses may exhibit their loyalty by covering up some of the impaired physician's actions. Colleagues should realize that assisting the impaired physician in this matter, while dealing with the immediate symptoms, does not address the underlying problem.

Once an impaired physician problem has been identified and documented, it should be reviewed with the appropriate department chief, chief-of-staff, and possibly to a group of selected professional colleagues for resolution.

The administrator's role is to provide guidance and advice to this group of physicians and be sure that they appropriately address the problem. Getting this group to take action often will require a great deal of reinforcement by the administrator, since physicians are characteristically reluctant to become involved in taking action against one of their colleagues. Quite often the impaired physician will deny his problem and may seek to undermine or intimidate his colleagues and the administrator. The administrator should attempt to avoid direct confrontation with the impaired physician and work through the medical staff.

In many instances, however, either due to the procrastination of the medical staff, or the outright refusal to take action, it becomes necessary for the administrator to directly step in. The medical staff's reluctance to act may be based upon the fact that:

1. The impaired physician may be popular with the medical staff, colleagues may be sympathetic, and peers may be reluctant to personally or professionally harm the physician.
2. The members of the medical staff are generally not directly affected by the actions of an impaired colleague.
3. The medical staff may be reluctant to set a precedent through their action and may personally wonder if "they are next." After all, many physicians would contend that every doctor is entitled to "bad" days just like anyone else.
4. Some physicians may be vulnerable to economic reprisals from the impaired physician, and his friends—referral patterns may be altered.

These are just some of the reasons a physician group may hesitate to become involved. If the medical staff fails to take action, the administrator has no choice but to personally intervene on behalf of the Board of Trustees and community as well as to prevent the physician's professional career and personal life from self-destruction.□

9 The impaired physician and role of the county medical society

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THROUGH THE YEARS the Impaired Physician Program of the Medical Society of Milwaukee County has received more than 90 referrals—some of them from concerned colleagues, but most from frustrated and frightened family members and patients. A few impaired physicians have taken the courageous step to approach us either directly or through an intermediary, such as a member of the clergy.

Ours is not a treatment program. Rather, we provide a mechanism for compassionate, confidential, no-nonsense intervention. We get great response to our letter asking the MD to join representatives of the medical society on a matter of urgent mutual concern. We confront the physician at the work setting or hospital if appropriate. We assist the physician in assessing the extent of the impairment, identify options for the most appropriate immediate treatment, help our colleague in obtaining that treatment, monitor rehabilitation for at least two years, and act as an advocate if and when it is determined that professional duties can be resumed.

We work very closely with DePaul Rehabilitation Hospital in Milwaukee, which administers the monitoring protocol for our Committee, and which is one of several alternative facilities which

we identify to the impaired physician. Other alternatives range from local inpatient or outpatient programs to specialized institutional settings as far away as Georgia.

The Milwaukee County Society Committee includes several members who are, themselves, recovering from alcohol, drug, or psychiatric impairment. They have that special ability to put the impaired physician at ease, and to break down the barriers of rationalizations and denial. They consistently turn an otherwise humiliating and ugly confrontation for the impaired physician into a productive evaluation of a matter of mutual concern.

Physicians who have started on the road to recovery through our County Society program have all but unanimously praised it. They can personally attest to its complete confidentiality. No correspondence, no minutes, no specific reports to the Society Board of Directors. Those who make referrals to the Committee have also learned that their confidentiality is preserved. Very seldom does the impaired physician inquire as to who made the referral. When this happens, the Committee responds by saying that the information has come from "persons close to you who care very much and are concerned about your welfare."

When a report about possible impairment is initially received—usually by a phone call to our Executive Vice President—we question the individual making the referral to verify the authenticity of the report. Of the 90 plus referrals our Committee has processed, in only one instance was there insufficient objective evidence to substantiate the report.

With very few exceptions, the impaired physician is persuaded to acknowledge and confront the problem at the initial meeting with members of the Committee. A plan for rehabilitation treatment and monitoring is mutually developed and agreed upon. It is not at all unusual for us to have the impaired colleague under active treatment within 24 hours. Depending upon the cause and extent of impairment, we assist the physician in temporarily curtailing practice, changing to a less stressful professional atmosphere, or retiring with the dignity that a lifetime of dedicated service deserves.

During our nine years of experience, only three physicians have refused to acknowledge their *obvious* impairment, and to cooperate with the Committee. In all three instances we advised the physicians that our obligation to protect the safety of the public required us to refer the reports and our own findings to the Medical Examining Board.

In a community the size of Milwaukee, intervention by an impaired physician's colleagues may be somewhat easier than in communities where most physicians are on a first-name basis. In that case the County Society should take advantage of the State Society's program where intervention and assistance is just as compassionate, but less complicated by personal ties, than on the home front.

If our experience in Milwaukee has taught us anything, it is to *acknowledge* that physician impairment does exist, and that the County Society must be *assertive* if we are to be of any real help to these less fortunate colleagues and—at the same time—protect the welfare of the patient community.

As with any other disease, true kindness lies in bringing the illness behind impairment to treatment—not in efforts to conceal or abandon our brethren in the profession.□

10 Role of the Medical Examining Board

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Member, Wisconsin Medical Examining Board

THE MEDICAL EXAMINING BOARD is the statutory body which the Legislature has created to administer The Medical Practice Act. This act governs the licensure of physicians, regulates their professional activities, and protects the public by investigating complaints and taking disciplinary action in matters of unprofessional conduct.

The Coordinating Council on Physician Impairment was created in May 1980 by agreement between the State Medical Society of Wisconsin and the Medical Examining Board. The charge called for establishment of a statewide impaired physician program. The Society and Board coordinate their work so that appropriate information is shared and actions can be taken should a physician fail to respond to treatment and rehabilitation for impairment or *immediately* when the Board deems it necessary in order to carry out its statutory mandate to protect the public. The Council initiates and promotes educational programs on impairment with various medical and other professional groups so there is better understanding of addictive and mental disorders and that help is available through the Impaired Physician Program. An Impaired Physician Committee has been established as a Committee of the State Medical Society Commission on Mediation and Peer Review. This Committee has primary responsibility for implementing the statewide Impaired Physician Program through the policies and guidelines set up by the Coordinating Council. If treatment or rehabilitation is rejected or fails or does not adequately protect the public, such cases are reviewed with the Coordinating Council so

that Medical Examining Board input is part of the decision-making process. DePaul Rehabilitation Hospital's Impaired Physician Program or other institutions with expertise on impairment will assist in training the Society's Impaired Physician Committee members: (1) in the techniques of intervention and consultation services, (2) on recruitment of physicians for committee membership, (3) on referral policies and procedures for treatment and, (4) in educational programming. The Council and the Impaired Physician Committee will also conduct a thorough study of the extent of impairment among Wisconsin physicians and publicize the results. It is estimated that between 10% and 15% of physicians are in some state of alcoholism or other drug addiction.[1] Wisconsin, with slightly more than 6,000 physicians, could potentially have between 600 and 900 physicians suffering from some degree of chemical dependency. But the need for more accurate data, reflecting and including other areas of impairment such as senility, psychiatric disorders and physical disorders, would be important.

There still exists the need to review the statutes and make legislative changes where there are impotent and/or ponderous state laws. Lawmakers in many states have demanded that physicians take an active part in policing their own members and have passed a number of new laws, ranging from mild expansion of statutes already on the books to establishing what amounts to a medical police force in California. The majority of the states have taken one or more of these steps to promote stricter disciplining of physicians:[2]

- Providing legal immunity for physicians who report colleagues to disciplinary boards.
- Making such reporting mandatory for physicians—and in some states for hospitals, medical societies, and malpractice insurers. Our Medical Examining Board has introduced a bill presently under consideration by the Legislature that requires hospitals to notify the Medical Examining Board whenever a hospital staff member who is licensed by the Examining Board resigns from the hospital staff or loses or has his or her hospital staff privileges reduced.

  The bill also provides that if a license issued by the Medical Examining Board has been summarily suspended by the Board pending a hearing, the Board may subsequently suspend the license from the time a hearing is held until a decision is issued.
- Adding new grounds for disciplining physicians, including incompetence.
- Making the penalties more flexible.
- Putting discipline in the hands of new agencies separate from the licensing boards.
- Giving the disciplinary boards new powers, such as subpoenaing records and invoking summary license suspension.

All this legislative activity has had some impact, with actions against physicians taking a tremendous upsurge. However, much of the new legislation is geared to rehabilitating physicians rather than punishing them.

In Wisconsin when a complaint against a licensee is received, it is screened by the Secretary of the Medical Examining Board. The purpose of the screening is to determine whether the matter is something over which the Board has jurisdiction. Once the screening is complete and a jurisdictional decision is made, it is referred to the Division of Enforcement for an investigation. If disciplinary action is justified, a formal complaint is made and a hearing is scheduled. Following this, a proposed decision is transmitted to the Board which determines whether to affirm, reverse, or amend the action. The Board's options in disciplinary matters are: dismissing the complaint, reprimanding the licensee, or suspending, limiting or revoking the license. A physician who loses his/her license, or has the scope of practice limited due to an impairment, is referred to a rehabilitation program and is closely monitored. His/her adherence to the program and the rate of recovery will be the determining factors in lifting the practice limitations and/or the restoration of the license. The Board makes every attempt to work with the physician who makes an effort to solve his/her problem and recapture their professional integrity. However, the Board would like to see the physician seek rehabilitation as soon as a problem exists and before the public suffers some harm because of an impairment. It is a known factor that very few physicians report the physician that they know to be impaired. Physicians have a propensity for denying illness among their own associates, even though the American Medical Association has repeatedly emphasized that it is an ethical responsibility for members to report such physicians.[3]

I look forward to the coordination of efforts between the State Medical Society and the Medical Examining Board and applaud the work of those Wisconsin physicians in the forefront of the movement toward physician helping physician. The Board would hope that more physicians would report colleagues who are having impairment difficulties. I feel it is one of the important ways to protect the public, upgrade the standards of the medical profession, and improve the quality of healthcare in Wisconsin.

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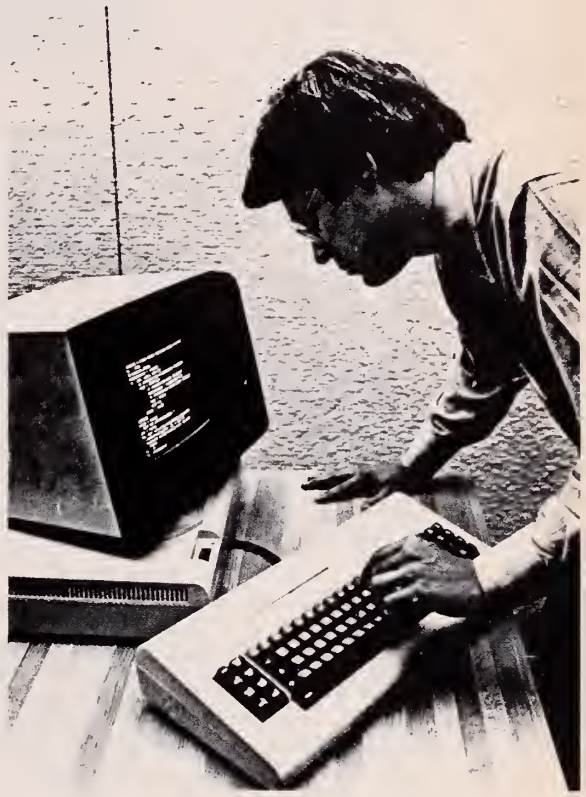

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THE QUESTION OF

COMPUTERIZATION

NO. 1 OF A SERIES

SINCE ABOUT 1950, we have witnessed the growth of a new technology, of electronic information processing. Slowly at first, but at an ever-accelerating rate, digital computers of all sizes have diffused throughout the fabric of our culture. First, the universities and all branches of the government, then industry and commerce, and now our homes have welcomed this versatile assistant, advisor, and entertainer; to the point that, even now, it would be highly inconvenient (if not indeed disastrous) if all the computers were to be removed. And still the proliferation advances apace. ¶In particular, the field of medicine has seen the steady computerization of its activities; from the largest hospital complex to the smallest individual office; from accounting and billing to diagnostic aids, statistical recordkeeping, and intensive-care monitoring. Tomography, blood-chemistry, and dietetic planning are now fully computerized; as are the physician's quartz-digital watch, his bank-account, his microwave oven, his flight reservation, his camera (and the design of its lenses), his insurance premiums, . . . ¶In this environment, more and more people are wondering how soon and in what manner to begin using computers in their own activities, what computer systems to adopt, which services to employ, how much of their work to computerize, what software to purchase, how much to spend; and perhaps, too, they wonder how it all works and what the jargon means. The choices offered, and the attendant claims, are bewildering; and it is not too wise to buy a computer system first and learn the facts later. ¶In view of this, it was decided to publish in the Wisconsin Medical Journal *a series of brief articles, explaining in simple terms what computers are, what their languages and programs can do, what the technical terms mean, and what the available choices are (though these last are changing and multiplying almost daily, the general outline remains relatively stable). While the text will be principally didactic and prestructured, the author would be happy to hear from his readers, deal with matters of general interest, and perhaps have question-and-answer sections from time to time.*

The second industrial revolution

John H Halton, MA, DPhil, FIMA, FBCS, Madison, Wisconsin

THE WORLD IS undergoing a major social and economic change, a Second Industrial Revolution, through the new information processing technology of communications and computers. While Mankind has developed a myriad ways of applying and controlling power to dominate and shape our environment, through the use of tools, weapons, machines, fuels, vehicles, instruments, clothing, buildings and roads, metals, plastics and drugs, agriculture, and electricity; the handling of information has lagged considerably, perhaps because the human brain is itself so remarkably powerful. Until recently, there have been only three major developments in this area: the invention of written (or painted or carved) language, some five or six thousand years ago; that of simple arithmetic operations, using what would now be called a digital representation of numbers, about a thousand years later; and that of printing, about five hundred years ago.

With written language, we get the capacity to make a permanent record of information and also to convey messages across space and time: *storage, retrieval,* and *communication.* With digital arithmetic, we get the ability to perform accurate, repeatable *manipulations* of *quantitative data.* With printing, we can make many identical copies of the same record and so *broadcast* a single message to a wide and continuing audience. Beyond these outstanding advances, until the last hundred years or so, the only progress has been in the engineering and increasingly plentiful production of more powerful and reliable and efficient, faster and cheaper devices to implement these concepts

Doctor Halton is Professor of Computer Sciences at The University of Wisconsin, Madison. Communications may be directed to him at 707 South Dickinson Street, Madison, Wisconsin 53703 (phone: 608/255-2667). Copyright 1982 by the State Medical Society of Wisconsin.

(such as styli, chalks, brushes, and pens; slates, wax tablets, papyrus, parchment, and paper; typewriters; abaci, cash registers, and calculating machines; movable type and typesetting machines; and printing presses of increasing speed and complexity).

In the last hundred years, we see the rapidly accelerating advent of a technology so powerful, novel, widespread, and influential that we may indeed call it the Second Industrial Revolution. Its basis is electromagnetic, in many interconnected forms: photography, photocopying, cinematography, and holography; telegraphy, telephony, radio communication, radar, sonar, and telemetry; sound and video recording and reproduction; vacuum tubes, transistors, printed circuits, masers, lasers, fiber optics, and (in rapid succession) integrated circuits (IC), large scale integration (LSI), and very large scale integration (VLSI) of circuitry on a tiny semi-conducting 'chip'; and, finally, the bewildering variety of electronic digital computers. All these devices are intimately interrelated, and any advance in one tends to generate advances in all of them.

The progress has been truly amazing. In only about forty years, electronic communications and news media have become commonplace and indispensable; computers have proliferated, becoming increasingly fast, powerful, small, and cheap; so that now there is scarcely a human activity in which they are not to be found, bearing an increasing share of the burden of repetitive information processing, just as the machines of the First Industrial Revolution have taken over the majority of heavy and unpleasant physical labor (we may say, energy processing).

Now, information can not only be stored, retrieved, communicated, and broadcast in enormous quantities and at phenomenal speeds; but it can also be *rearranged, selected, marshalled,* and *transformed.* Until recently, these activities were the sole province of the human brain. While creative, judicious, moral, and esthetic choices are still best left to people, all the tedious and mechanical mental processes can now be relegated to the accurate, fast, and tireless machines. Any sequence of operations on information which can be precisely specified can be carried out without further human intervention or supervision.

At first, computers were the experimental toys of university researchers; then they became the tools of government establishments and giant corporations, huge, expensive, individually designed and manufactured, and beyond the reach of any but the wealthiest organizations. People thought of the future in terms of machines of ever-greater speed and capacity; centralized behemoths would hold all the world's information in gigantic data banks, whence major decisions would issue to be imposed upon the populations at their mercy. With the emergence of powerful, cheap, mass-produced computers-on-a-chip, the picture has changed radically. Now we see tiny computers everywhere: in wrist-watches, microwave ovens, electronic games, pocket calculators, cameras, typewriters, musical instruments,. . . What used to be done, with few options, by intricate mechanical devices is now performed, with great flexibility and convenience and at much less expense, by the ubiquitous preprogrammed microcomputer. The probable future has become one of millions of small yet powerful computers, controlling virtually every machine and appliance, distributed in every home, on every desk, in every workshop; many of them connected in a maze of small and large networks, much like the present telephone network (and perhaps replacing it), so that individual computers could communicate, sharing information in a gigantic distributed data-base and gaining, through distributed proces-

About the author

JOHN H HALTON was educated in England and has lived in the United States since 1962. He holds the degrees of BA and MA from Cambridge University in mathematics and physics, and the MA and DPhil from Oxford University for research in computational methods and the Monte Carlo method. He is a member of the Oxford University Faculty of Physical Sciences and has the professional ranks of FIMA and FBCS. He has taught mathematics and computer sciences at Cambridge, Oxford, Illinois, Adelphi, and Colorado universities, before coming to The University of Wisconsin in Madison, where he is Professor of Computer Sciences since 1969. He has done research at these universities and for the British War Office, English Electric Co., Clarendon Laboratory, Brookhaven National Laboratory, RAND Corp, John Deere Co, and the US Army Mathematics Research Center, in a broad range of problems, from nuclear reactions to the hydrodynamic lubrication of bearings, from the evaluation of the effectiveness of personnel-selection tests to the generation and analysis of quasi-random numbers, and from the design of VLSI microcomputer chips, efficient multi-computer networks, and formula-manipulation languages for computers to the statistics of tree-structures, antithetic transformations for variance-reduction, algebraic identities, and probabilistic algorithms for shortest-path problems. He is the author of about a hundred research papers and technical reports, and is regularly asked to review books, papers, and research proposals. He has 27 years' experience of a wide variety of computers, their languages, and their applications. In addition to teaching many courses on computers, programming, and numerical methods, he regularly teaches the UW course on Computers and Society. He also is a consultant to industry.

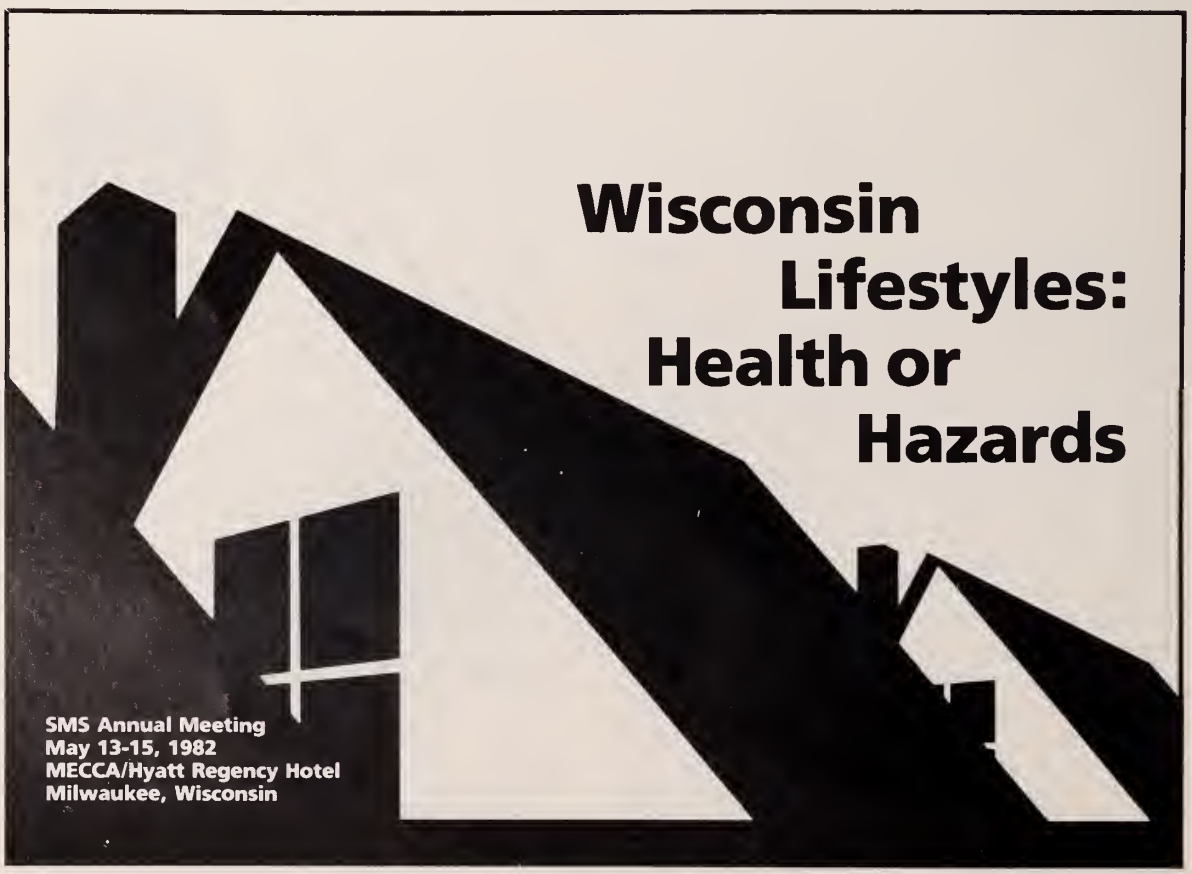
Doctor Halton

sing, computational power whose extent is yet difficult to gauge; all this following the individual requirements and choices of the owner or operator of each machine.

Increasingly, we are confronted, not only with the results of the use of computers throughout industry, commerce, banking, advertising, science, the communications industry, newspapers, airlines, and hospitals; but with the realistic possibility of purchasing computer power for our own small enterprises, offices, and homes. This may be done in a variety of ways; but in all of them, the real cost of computation is constantly diminishing. It is probably fair to say that the question of computerization is not "whether," but "when" and "how." We must choose whether to lease equipment or to buy it; whether to install terminals, connected to a computerized 'service bureau,' or a complete local computer system; whether to get a package of standard programs directed towards our kind of work, to commission new programs tailored to our special needs, or to learn programming and write our own; whether to go it alone or to share a system with a number of similar users (especially if they are in the same building); how far to take our first efforts at computerization; what to include and what to continue doing by hand. Then, having made the broad choices, we must select, from the wide range of available products those which will suit our situation best.

Computer programming is likely to become the literacy of the third millenium A.D. Elementary schools may well be teaching it, before long, and we might be well-advised to gain at least a smattering of knowledge of computers and of programming competence, especially since computer languages and programming environments are becoming increasingly helpful and friendly to the uninitiated user.

In subsequent articles, I propose to outline the nature of computers and their parts, their languages, and their programs, and to discuss the choices confronting the potential buyer of a modest system in answering the "question of computerization." In this connection, I would be happy to hear from interested readers, either about their experiences in setting up their first system, or concerning aspects of the matter that most interest or baffle them.■



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Board votes to expand impaired physician effort

The SMS Board of Directors, March 13, approved a stepped-up program for dealing with physicians suffering from alcoholism, other drug dependency, psychiatric disorders, or physical disability. The $33,000 statewide program will be funded through the Society's Charitable, Educational and Scientific Foundation with financial and professional support from the State Medical Society and DePaul Rehabilitation Hospital in Milwaukee.

According to SMS President-elect and Impaired Physician Committee Chairman Gerald C Kempthorne, MD, Spring Green, the new effort will greatly expand the Society's current program which began in 1977. That program tries to identify, intervene with, and provide treatment for impaired physicians.

"We cannot condone impaired physician behavior, nor can we look askance in the presence of a sick doctor," Doctor Kempthorne said. In addition, "the medical profession has a fundamental obligation to care for their colleagues."

"If this effort is to succeed, the medical profession will need the assistance of others involved in healthcare delivery, family members and patients to ensure that impaired physicians get the help they so desperately need and that patient care goes unharmed."

Phase I of the new proposal will center on education and prevention efforts. "The most immediate problem is to educate target individuals and groups about physician impairment, its symptoms, the need and techniques of early identification and intervention, what resources are available to help the impaired physicians, and finally what social, financial, legal, or other problems come into play when dealing with physicians suffering from an impairment," Doctor Kempthorne said.

"The key to our effort is that we're no longer just talking about physicians reaching out to help other physicians," says Doctor Kempthorne. "We're also going to those people who frequently come into contact with physicians such as hospital administrators, nurses, pharmacists, nursing home administrators, and spouses and families of physicians to teach them how to identify the problem and seek help for the individual involved."

Doctor Kempthorne feels there is evidence that impairment among physicians exists to a substantial degree beyond what is now being identified by existing physician impairment programs.

"Most of the literature on the impaired physician contends that 10% to 14% of practicing physicians 'have problems with alcohol and drugs,' " he said. "From this we can conclude that a number of 'problem users' and the number of actual 'impaired' physicians are significantly higher than what Wisconsin's impaired physician programs are currently recording as identified cases."

Another reason for educational programming is that those persons in a position to help are very often reluctant to do so. "The reaction is very often 'I don't want to get involved,' or 'that's his/her problem, ' " Doctor Kempthorne said.

The second phase of the program centers on recruitment and training of volunteer physicians to intervene (confront) other physicians identified as impaired. These physician volunteers will take part in training sessions on identification, intervention, treatment resources, and followup and will acquire experience by working with a

Appearing in this issue is a special feature on the Impaired Physician, containing 10 articles; see pages 21-38.

DR&L Secretary Haney appears before Board of Directors

Dept of Regulation and Licensing (DR&L) Secretary Ann Haney met with the SMS Board of Directors, March 13, to discuss her proposals for revamping the Department, the activities and responsibilities of the Medical Examining Board, and the ongoing licensing and disciplinary activities affecting physicians.

Haney said next on her agenda will be bills to regulate. While noting that she will not be recommending any more bills like SB 787, a bill which would have transferred many authorities of the Medical Examining Board to the Dept of Regulation and Licensing, she will be recommending that certain licensing boards be eliminated and that other boards be drastically reduced. She assured the physicians present that she had no plans for eliminating the medical board.

Secondly, Haney is looking at bills to enhance regulation, or more specifically, to clarify in the statutes each examining board's authority to discipline. "Currently," she said, "each board has anywhere from three to twelve grounds for disciplinary action. Recent court decisions have diluted some of the examining board's grounds for discipline. Before proceeding with any legislation, Haney said she will be looking for support from the boards and the professions.

The Department Secretary also noted that more interpractice rules were necessary to protect the public and that a set of standards needs to be developed for all health boards to follow in disciplinary actions.

"Currently it takes twice as long to investigate and closeout a disciplinary case in the health professions as opposed to business," Haney said. ■

physician already experienced in intervening with impaired physicians.

After the impaired physician is approached and urged to seek help, the physician volunteers will provide the impaired physician with several options of treatment facilities and services within the state. Once into the rehabilitation and treatment process, the State Medical Society will monitor the physician's progress and long-term recovery.

Implementation of the new program will rest with a managing committee consisting of representatives from the State Medical Society of Wisconsin and DePaul Rehabilitation Hospital. In addition, the managing committee will continue to work with the Coordinating Council on Physician Impairment of the State Medical Society and Medical Examining Board to ensure that appropriate action can be taken by the Board should a physician fail to respond to treatment and rehabilitation for impairment. ■

More Board of Directors Action March 13

In other action March 13, the SMS Board of Directors:

• Approved a 1982 State Medical Society budget of $1,710,000; subject to House of Delegates okay.

• Agreed to jointly seek an amendment to Section 146.82, *Wisconsin Statutes,* relating to confidentiality of medical statutes with the Wisconsin Hospital Association and the Wisconsin Freedom of Information Council. The legislation is necessary in order for the three groups to proceed in negotiating a revised "Communications Guide for Hospitals, Physicians and News Media." The proposed amendment reads:

> "**146.82 (2) (c):** Information concerning name, age, sex, address, occupation, general condition and nature of injury may be released during treatment of a patient at a health care facility, unless the patient or representative of the patient specifically requests that such information not be released."

• Will seek a legal opinion on the document: "Physician Guidelines: Blood Alcohol Testing" to see if a revision is needed in light of a new law relating to operating a motor vehicle while intoxicated.

• Appointed the following SMS Auxilians to SMS committees: Mrs Charles Desch, Waukesha, to the Committee on Aging and Extended Care Facilities, and Mrs. Kenneth Smigielski, Milwaukee, to the Committee on School Health.

• Opposed a provision in the Budget Adjustment Bill which would amend the Medical Practice Act's definition of "unprofessional conduct" to include a physician who conducts artificial insemination on a woman "who the physician knows or has reason to believe is on Medical Assistance or who would be eligible for Medical Assistance as a direct result of the birth of a child conceived by means of artificial insemination." However, the Board agreed that consideration should be given to ethical guidelines for physicians in the use of this medical procedure.

• Agreed to establish an Ad Hoc Committee of SMS and Wisconsin Nurses Association representatives and appointed Michael P Mehr, MD, Marshfield; Carl S Eisenberg, MD, Milwaukee, and Albert J Motzel Jr, MD, Waukesha, to represent the Society.

• Set the following Board meeting dates for 1982-83: July 17, 1982 (Board meeting to be held at the Medical Museum at Prairie du Chien with the CESF Board of Directors meeting to follow); September 11, 1982; November 13, 1982; January 15, 1983, and March 23, 1983 (SMS Annual Meeting March 24-26).

• Forwarded a proposed format for county medical society meetings to the 1982 SMS House of Delegates. The new format emphasizes scientific affairs and would call for all county society officers to be installed in January each year.

• Agreed to bestow the Presidential Citation Award of the Society posthumously to former SMS employee Parks Reinhardt.

• Viewed a videotape of Chicago Bear player Dennis Lick speaking on his alcoholism at the 1981 Work Week of Health. The tape will now be sent to Wisconsin schools for use in health education classes.

• Reaffirmed its endorsement of the uniform casualty report form, and recommended completion of the report without charge.

• Supported Senate Joint Resolution 49 which proclaims the week of April 18 to 24, 1982 "Ground Zero Week" in Wisconsin. The Board's action is intended to emphasize education of the public on the medical and health issues presented by nuclear war.

• Okayed a recommendation from the SMS Committee on Safe Transportation to ask the AMA to develop Patient Medication Instruction inserts warning drivers of the influence of certain medications on driving ability.

• Voted to encourage physicians and clinics, and their employees, who come in contact with rubella patients, pediatric patients, or female patients of childbearing age, to either document vaccination against rubella, or provide evidence of a laboratory test indicating immunity to rubella.

• Opposed a recent amendment to a bill recodifying the pharmacy practice laws in the state. The amendment, sought by the Wisconsin Nurses Association, would permit registered nurses to prescribe under the written protocol of a physician, dentist, podiatrist, or other person specifically authorized by law to prescribe drugs.

• Approved a "Statement on Terminal Care in Long-Term Care Facilities" prepared by the SMS Committee on Aging and Extended Care Facilities. (For a copy contact Bill Wendle or Arlene Meyer at SMS offices; it will also be published in the 1982 "Blue Book" of WMJ.)

• Approved a revised "Statement on Oxytocics" prepared by the SMS Committee on Maternal and Child Health. (Copies available from Bill Wendle or Arlene Meyer; it also will be published in the 1982 "Blue Book" of WMJ.)

• Approved a request by the SMS Committee on Women Physicians that the topic of Premenstrual Syndrome (PMS) be incorporated into the 1983 Annual Meeting, and authorized the committee to develop a study of PMS for report back to the Board.

• Received a report from the Society's AMA Delegation regarding actions at the 1981 Interim Meeting of the AMA House of Delegates.

• Voted to recommend to the SMS House of Delegates that SMS dues be increased by 4.9% in 1983. The Board considered the fact that the 1981 CPI (all items) increased 8.9% and the Physician's Index increased 11.7%.

• Received a list of "Interviewing Tips" to keep in mind when being interviewed by print or broadcast media. (For a copy contact Diane Upton at SMS offices.)

• Appointed A James Bennett, MD, Kenosha, and Jerome W Fons Jr, MD, Milwaukee, to the SMS Services, Inc Board of Directors.

• Received a report from the SMS Ad Hoc Committee on Health Practitioners which makes a number of recommendations designed to strengthen the quality of patient care by improved relationships between physicians and other health practitioners. The Board will act on the report at a later meeting.

• Appointed the following physicians to SMS Committees and Commissions: James V Seegers, MD, Elkhorn, and John W Faber, MD, Neenah, to the Committee on Medicine and Religion; George L Gay Jr, MD, Cambridge/Fort Atkinson, to the Commission on Public Information; Rolf L Simonson, MD, Sheboygan, to the Committee on School Health, and Roland R Liebenow, MD, Lake Mills, to the Committee on Aging and Extended Care Facilities. ■

May 15 deadline for payment of SMS membership dues

Physicians are reminded that the newly revised Constitution and Bylaws, as adopted by the 1981 House of Delegates and printed in the June 1981 *Blue Book* issue, state that "any member whose current year's dues have not been received by the secretary of this Society by May 15 shall be deemed in arrears and his name shall be removed from the membership rolls of his county society and this Society until such time as full dues for the current year have been received."

MEMBERSHIP DIRECTORY CORRECTIONS

Corrections to the Membership Directory as published in the January issue of WMJ, by county medical society, should be noted as follows:

Barron-Washburn-Burnett: Change specialty from GP-General Practice to FP-Family Practice for Lloyd R Cotts, MD; John T Henningsen, MD; Lowell A Kristensen, MD; and Lester A Thompson, MD, all of Rice Lake.

Dane: Delete secondary specialty of OPH-Ophthalmology for Stanley L Inhorn, MD, Madison.

Green: Change secondary specialty from ORS-Orthopedic Surgery to CRS-Colon and Rectal Surgery for Don G Traul, MD, Monroe.

Marinette-Florence: Change primary specialty from CLP-Clinical Pathology and secondary specialty from P-Psychiatry to ATCLP-Anatomic and Clinical Pathology as the primary specialty for Jon L Keller, MD, Marinette.

Milwaukee: Change primary specialty from OS-Other specialty than a designated specialty in this directory to CLON-Clinical Oncology for Gerald J Kallas, MD, Milwaukee; change address from General Delivery, Duluth, MN 55806 to Box 353, Minong, WI 54859 for Maurice Bakaleinik, MD; change primary specialty from IM-Internal Medicine to CD-Cardiovascular Diseases and make IM-Internal Medicine the secondary specialty for Alfonso L Tiu, MD, West Allis.

Oneida-Vilas: Change primary specialty from GP-General Practice to GS-General Surgery and add VS-Vascular Surgery as the secondary specialty for Irving E Schiek III, MD, Rhinelander.

Racine: Change primary specialty of OBG-Obstetrics and Gynecology to GYN-Gynecology for Leo R Grinney, MD, Racine.

Sheboygan: Change primary specialty of GS-General Surgery to ABS-Abdominal Surgery and add FP-Family Practice as the secondary specialty for Jose Q Tolentino, MD, Adell.

Waukesha: Delete secondary specialty of PDR-Pediatric Radiology for James A Alston, MD, Waukesha; transfer from Milwaukee Society to Waukesha Society for John S Cantieri, MD, Brookfield.

Wood: Change the first name from Michael to Michel for Michel Y Roy, MD, Marshfield.

The above corrections were provided to the Journal by the physicians involved and were due to inadvertent or administrative errors on the part of the Journal and/or the Membership Department for which apologies are extended. Membership records as well as the Journal Directory listing have now been corrected. ■

State Medical Society of Wisconsin

PROGRAM SCHEDULE—Annual Meeting, May 13-14-15, 1982, Milwaukee

THURSDAY, MAY 13

Section Delegates Caucus
MECCA, 8:00 am

Registration H/D
MECCA, 8:00 am

House of Delegates First Session
MECCA, 9:00 am

Reference Committee Meetings
Hyatt/Lobby, 1:00 pm

District 1 Caucus
MECCA/2nd Fl, 1:00 pm

HMO-IPA Conference
MECCA, 3:00 pm

Presidents' Reception and Dinner
Hyatt, 7:00 pm

FRIDAY, MAY 14

Medicine & Religion Breakfast
Hyatt, 7:00 am

Mental Retardation Panel
MECCA, 9:00-12:00 noon

Socio-Economic WISPAC Luncheon
Hyatt, 11:45 am

Registration H/D
MECCA, 1:00 pm

District 1 Caucus
MECCA, 1:00 pm

House of Delegates Second & Third Sessions
MECCA, 1:45 pm

Review of Current Concepts in Adolescent Development, Sexuality, Contraceptive Decision-Making, & Complications of Pregnancy—Panel
MECCA, 1:45 pm-4:45 pm

Women in Medicine Program
Hyatt, 5:30 pm

Women in Medicine Dinner
Hyatt, 7:30 pm

Past Presidents' Reception and Dinner
Hyatt, 6:00 pm

Neurology Specialty Program and Luncheon
MECCA, 12:15 pm-4:30 pm

Ophthalmology Specialty Program, Luncheon, and Business Meeting
MECCA, 8:00 am-5:00 pm

Ophthalmology Social Hour
Hyatt, 5:30 pm

Orthopaedics Specialty Program, Luncheon, and Business Meeting
MECCA, 8:30 am-4:30 pm

Orthopaedics Dinner & Program
Milwaukee Athletic Club, 6:00 pm

Physical Medicine & Rehabilitation/ Pediatrics Specialty Program & Business Meeting
MECCA, 1:30 pm-5:00 pm

Plastic Surgery Specialty Program, Luncheon, and Business Meeting
MECCA, 12:15 pm-4:30 pm

Public Health & Preventive Medicine Specialty Program, Business Meeting
MECCA, 2:00 pm

Socio-Economics/WISPAC Luncheon
Hyatt, 11:45 am

Radiation Oncology Specialty Program
MECCA, 9:00 am-11:00 am

Resident Physicians Section Specialty Program
MECCA 9:00 am-4:00 pm

SATURDAY, MAY 15

Adolescent Alcoholism and Drug Panel
MECCA, 8:00 am-10:00 am

Adolescent Suicide, Violence and Other Problems—Panel
MECCA, 8:00 am-10:30 am

Allergy and Clinical Immunology Specialty Program and Luncheon
MECCA, 12:15 pm-4:00 pm

Anesthesiology Specialty Program, Luncheon, and Business Meeting
MECCA, 12:15 pm-5:00 pm

Cardiovascular Problems in the Adolescent—Panel
MECCA, 10:15 am-12:15 pm

Dermatology Specialty Program and Luncheon
MECCA, 12:15 pm-4:30 pm

Emergency Medicine Specialty Program and Business Meeting
MECCA, 1:00 pm-3:30 pm

Internal Medicine Specialty Program and Luncheon
MECCA, 12:15 pm-3:30 pm

Neurosurgery Specialty Program and Luncheon
MECCA, 12:15 pm-2:00 pm

Otolaryngology Specialty Program, Luncheon, and Business Meeting
MECCA, 8:30 am-4:00 pm

Pathology Specialty Program, Luncheon, and Business Meeting
MECCA, 9:30 am-5:00 pm

The Politics of Organized Medicine
MECCA, 9:00 am

Surgery Specialty Program, Luncheon, and Business Meeting
St Joseph's Hospital, 8:00 am-12:00 noon
St Joseph's Hospital, 12:00 noon
MECCA, 1:30 pm-5:00 pm

* * *

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Arlene Meyer, *Administrative Assistant, Continuing Medical Education*

Public health and cost containment are key issues

The House of Delegates will consider resolutions ranging in subject matter from the drinking driver and the smoker to cost containment issues and physician reimbursement at the State Medical Society's Annual Meeting in Milwaukee, May 13-15.

The following resolutions were received in the Secretary's office by the March 13 deadline. These will go to the House of Delegates for action during its three sessions at the MECCA in Milwaukee. Members are urged to express their opinions to their delegates (see page 54 for list) and to participate at the Annual Meeting Reference Committee hearings where resolutions are discussed.

Members are reminded that the first session of the House will start at 9:00 am Thursday, May 13, preceded by registration at 8:00. The second and third sessions will be held on Friday, May 14, starting at 1:45 pm with registration at 1:00. In previous years the second and third sessions have been held on separate days.

(The county medical society, specialty section, director, delegate, or individual physician who introduced the resolution appears in parentheses.)

1. (Eau Claire-Dunn-Pepin) No Allowable BAC Concept

Because alcohol impairment in drivers on the highways of Wisconsin has resulted in approximately 500 deaths and 5,000 injuries each year (10,000 deaths and 100,000 injuries during the past twenty years); and there has been no effective effort by the State of Wisconsin to prevent these tragedies; and present laws of the State of Wisconsin contain an allowable blood alcohol concentration (BAC) concept, establishing BAC limits which allow drivers to consume alcohol up to those limits, but with no method to determine their BAC, thus condoning impairment on the highway and the continuation of multiple deaths and injuries; and commercial transportation has provided an excellent example, showing that deaths and injuries due to alcohol impairment can be reduced or eliminated by not allowing pilots or drivers to have any BAC; therefore be it

"RESOLVED, 1) That the State Medical Society advocate the establishment of state policy that would permit *no* driver on Wisconsin highways to have any blood alcohol concentration; 2) That the State Medical Society advocate severe punishment of violations, varying with the severity of the violation and the degree of associated traffic liability. With a well-established principle of *no* BAC allowable in *any* driver, it would be understood that BAC up to 0.02 would incur no penalty, considering the limitations of any laboratory procedure."

2. (Manitowoc) No Allowable BAC Concept

"RESOLVED, 1) That the State Medical Society of Wisconsin advocate an official state policy that permits *no* driver on our highways to have *any* blood alcohol concentration. 2) That this Society also advocate severe punishment of violations, varying with the severity of the violation and traffic liability."

3. (Milwaukee) No Allowable BAC Concept

"RESOLVED, that the State Medical Society of Wisconsin advocates an official state policy that permits *no driver* on our roads to have *any* blood alcohol concentration, and be it further

"RESOLVED, that this Society also advocates severe punishment of violations, varying with the severity of the violation and traffic liability."

4. (Roger von Heimburg, MD, Director, Sixth District) No Allowable BAC Concept

"RESOLVED, that drivers on our highways be prohibited from having any blood alcohol concentration."

5. (Langlade) No Allowable BAC Concept

"RESOLVED, that the State Medical Society of Wisconsin go on record as being in favor of no allowable blood alcohol level in any driver on Wisconsin highways."

6. (Jefferson) Raising Drinking Age to 21

Because, according to the latest statistics from the State Bureau of Alcohol and Drug Abuse, it is estimated that there are 80,667 teen-age problem drinkers in Wisconsin between the ages of 12-20 and this represents 24% of all the estimated problem drinkers in the state; and it is a fact that teen-age alcoholic-related traffic deaths have increased in the past couple of years and now represent 14% of all traffic deaths; and according to the latest US figures, one out of seven students in high school is using or abusing alcohol or other drugs on a weekly basis; and according to a survey done in 1979, in Jefferson County alone there are 1,087 estimated teen-age problem drinkers; and the Jefferson County Medical Society advocates raising the drinking age to 21; therefore be it

"RESOLVED, that the State Medical Society of Wisconsin will work toward passage of legislation to raise the drinking age to 21."

7. (Brown) Motorcycle Helmet Law

Because increased disability and death have resulted from the repeal of the mandatory motorcycle helmet law; and the costs for the care of the brain-damaged and disabled motorcyclists are borne in large part by the taxpayers of the state; therefore be it

"RESOLVED, that the State Medical Society encourage the Wisconsin Legislature to re-enact a motorcycle helmet law."

8. (Milwaukee) Physician Reimbursement

Because members of the State Medical Society of Wisconsin recognize the urgency and complexity of escalating costs for health-related services and are striving to minimize this escalation despite very limited decision making authority; and it continues to be the position of the medical profession that the "usual, customary and reasonable" concept is the most appropriate way to

promote fair competition among physicians, and for third party payors to maintain reimbursement schedules; therefore be it

"RESOLVED, that the State Medical Society of Wisconsin through its House of Delegates reiterate unalterable oppostion to any third party schemes to develop reimbursement formulas based on "uniform" schedules."

9. (Milwaukee) Voluntary Cost Containment

Because it is a matter of public record (Consumer Price Index) that the nation's physicians have kept fee increases below overall inflation for the most recent five-year aggregate period (January '77 - January '82); and this achievement is the result of a cooperative Voluntary Effort by the profession through their county, state, and national organizations; and in the State of Wisconsin, Blue Cross-Blue Shield United of Wisconsin has presumed to take credit for medicine's leadership in cost containment programs; and Blue Cross-Blue Shield United of Wisconsin misleads the public by announcing arbitrarily determined reimbursement levels (which apply only to its own subscribers, and only for certain inpatient services), and advises that the public need not pay more than the Blue Cross-Blue Shield allowance; and Blue Cross-Blue Shield has a contractual relationship only with its own subscribers, not with physicians, and certainly not with the general public; therefore be it

"RESOLVED, that the State Medical Society of Wisconsin register its displeasure to Blue Cross - Blue Shield United of Wisconsin for these misrepresentations; and be it further

"RESOLVED, that the State Medical Society of Wisconsin Board of Directors appropriate up to $10,000 this year for a public education program to set the record straight in terms of the Wisconsin medical profession's commitment to—and participation in—voluntary cost containment programs."

10. (Brown) Medicine - Business Coalitions

Because the AMA House of Delegates, along with the American Hospital Association, Blue Cross & Blue Shield Associations, Business Roundtable Health Association of America and the AFL-CIO, has recently urged voluntary coalitions between medicine, business and industry; and business and industry pays a substantial percentage of the total health care bill in Wisconsin; and such communication between medicine, business and industry could lead to new initiatives in the financing and delivery of health care in Wisconsin; therefore be it

"RESOLVED, that coalitions between medicine, business and industry be formed throughout the State of Wisconsin at the county and at the state level."

11. (Brown) Cost Containment in Medicine - Business Coalitions

Because physicians must address business and industry concerns over rising health care costs; and physicians along with business and industry leaders share a common goal of reduced health care costs; and medicine, business and industry coalitions can promote cost awareness among workers and promote cost consciousness among physicians; therefore be it

"RESOLVED, that medicine-business coalitions involve county and state cost effectiveness and cost containment committees in their work."

12. (Brown) Early Return to Work after Disability or Illness

Because business and industry leaders in Brown County have expressed concern for delays in timely return to work of ill or disabled employees; and economic conditions require business and industry to function as efficiently as possible; therefore be it

"RESOLVED, that Wisconsin physicians redouble their efforts in communicating with personnel managers to insure that recovered employees have an early return to work."

13. (Brown) Deductibles and Co-payment in SMS Sponsored Insurance Plans

Because the Rand study has recently demonstrated substantial cost reductions in health insurance plans with deductibles and co-payment; and physicians encourage their patients to purchase insurance plans with deductibles and co-insurance; and many members of the State Medical Society would purchase such plans if they were available; therefore be it

"RESOLVED, that the State Medical Society sponsored insurance plan offer deductibles and co-insurance as an option."

14. (Brown) Deductibles and Co-payment in Health Insurance Plans

Because steps are necessary to restrain the growth in health costs; and the recent Rand Corporation study demonstrated significant cost savings in insurance plans with deductibles and co-payment; therefore be it

"RESOLVED, that health insurance plans in Wisconsin offer deductibles and co-payment as an option; and be it further

"RESOLVED, that the State Commissioner of Insurance be urged to require deductibles and co-payment on health insurance policies written in Wisconsin."

15. (Waukesha) Medicaid Tax Credits

Because the Medicaid financial status is precarious, to say the least; and the health providers (including MDs) are carrying the brunt of this dilemma directly and indirectly; therefore be it

"RESOLVED, that the state and federal legislative bodies take immediate action to provide personal tax credits for Medicaid services in lieu of financial remunerations (corresponding to the failure of these bodies to meet their contractual obligations); and be it further

"RESOLVED, that in the case of incorporated physicians, the corporation would be allowed to assign tax credits to the individual physicians."

16. (Milwaukee) Medicaid Medical Psychotherapy Services

Because the State Medical Society of Wisconsin has waged a vigorous but unsuccessful effort to restore medical psychotherapy services to the Medical Assistance (T-19) Program; and this is considered an essential and legitimate modality within the practice of medicine; and the indigent should not be deprived of this basic service, and physicians should also not be deprived of a fee for rendering the service when deemed appropriate; therefore be it

"RESOLVED, that the State Medical Society of Wisconsin institute a formal legal action against the Department of Health and Social Services (DHSS) in a further

effort to have this service restored to the Medical Assistance Program."

Fiscal Note: When about five years ago the Society instituted a legal action against the state on a Medicaid issue, the costs exceeded $60,000. The cost would be considerably higher today, but the actual expense incurred would hinge on the complexity of the case, the length of the proceedings, and the nature of appeals, if any.

17. (Lincoln) Medicaid Second Opinion Program

Because the Second Opinion Surgical Program of Wisconsin Medical Assistance presents an undue hardship to patients and has not been shown clearly to be of financial benefit; therefore be it

"RESOLVED, that the State Medical Society strongly oppose reinstitution of a second opinion program."

18. (Jefferson) Funding for Local Health Departments

Because local health departments are the first line of defense for preventive medicine and public health education; and there are at present only 6 full-time countywide health departments, 2 full-time city-county health departments, and 13 full-time city health departments, which leaves the rest of the State of Wisconsin to be covered by nursing services or part-time health departments; and only the full-time health departments are able to offer a full range of services, including public health education, thus leaving a large portion of the population of Wisconsin with inadequate preventive medicine, inadequate public health services, and inadequate health education services, and increased funding of full-time local health departments is needed to support these needed preventive medicine and public health education efforts; therefore be it

"RESOLVED, that the State Medical Society request the Legislature to provide state funding for full-time local health departments, preventive medicine and health education."

19. (Milwaukee) Contingency Fee Limit

Because the attorney in a medical malpractice action is entitled to a fee commensurate with the time and effort spent in the action; and the attorney is placed at additional financial risk in contingency fee arrangements and, therefore, entitled to a larger fee; and the financial risk is reduced in contingency fee arrangements by the opportunity of a prior review of the plaintiff's medical records and the availability of medical consultation at reasonable cost; and contingency fee percentages of final settlements or awards are frequently unreasonably excessive; and an excessive contingency fee is unfair recompense for the attorney and deprives the patient of his or her intended compensation; therefore be it

"RESOLVED, that the State Medical Society of Wisconsin develop and propose legislation to limit the contingency fee of an attorney involved in a medical malpractice action to no more than twice the usual charge for time and other effort involved."

20. (Milwaukee) Contingency Fee Arrangements

Because contingency fee arrangements permit persons to initiate medical malpractice complaints without personal financial risk; and each medical malpractice complaint is a serious threat to the reputation and well-being of the involved physician; and the availability of contingency fee arrangements encourages malpractice complaints, increasing the number and adding to liability insurance premium costs; and the medical profession does not wish to obstruct any person's access to the courts but believes all parties in a legal confrontation should receive just and fair treatment; therefore be it

"RESOLVED, that the State Medical Society of Wisconsin seek the passage of legislation with provisions that 1) Court review of contingency fee arrangements be required prior to the submission of a malpractice complaint; 2) Contingency fee arrangements be permitted only where a plaintiff's inability to pay is proven and confirmed; 3) A plaintiff be required to pay for legal service in a malpractice action to the extent he or she is financially able; 4) After the court review, an attorney not be permitted to subsidize the legal action beyond the level set by the court in return for repayment based on a possible settlement or award, and 5) Guidelines be developed to assist and direct the court in its review."

21. (Dane) Medical Student Loans

Because considerable unfavorable publicity has been given to the medical profession as a result of physicians who have finished their training and who are not repaying federal loans which they obtained during their training; and not repaying these loans has resulted in a diminished amount of money available to make further loans; therefore be it

"RESOLVED, that the State Medical Society strongly urge all practicing physicians to repay federal loans they received during the course of their medical training."

22. (Rusk) Medical Student Loans

Because a substantial portion of the United States physician population would not have been able to undertake or complete their medical training without the benefit of educational loans; and physicians by virtue of their training enjoy comfortable incomes and numerous other privileges incidental to their profession; and significant numbers of these same physicians have discredited their peers by defaulting on these loans to the tune of approximately $3 million in federal or American Medical Association funds and $95,000 in Wisconsin State Medical Society funds alone; therefore be it

"RESOLVED, that the State Medical Society will yearly publish in the *Wisconsin Medical Journal* "Blue Book" the names of physicians who have defaulted on their State Medical Society, federal, or American Medical Association loans."

23. (Brown) Safety in Jogging

Because health conscious individuals continue to jog throughout all seasons of the year; and the presence of runners on the streets and thoroughfares of the communities in Wisconsin may occasion injuries or accidents to both runners and drivers; and a smooth running surface is better physiologically for the runner; and the runner should be under at least some degree of observation while jogging; therefore be it

"RESOLVED, that the various public and private running tracks most amenable to proper jogging activity be made available to the increasing numbers of health conscious individuals; and be it further

"RESOLVED, that the schools, colleges and universities make their running tracks available to the persons seek-

ing physical fitness so that their activities may be at least observed by other joggers and persons knowledgable in first aid matters; and be it further

"RESOLVED, that athletic directors, coaches and municipal authorities be encouraged to make public jogging facilities available to persons wishing them."

24. (Medical Student Section) Spouse Abuse

Because spouse abuse may be defined as a symptom complex in which any person, married or unmarried, over the age of sixteen has evidence of physical abuse on at least one occasion at the hands of an intimate partner; and the incidence of spouse abuse is estimated at between 4% and 16% per year in various representative populations of individuals in ongoing relationships; and victims of spouse abuse frequently seek help only when necessitated by the severity of physical injuries sustained during an episode of abuse; and the physician caring for the victim's injuries is often the only contact that person has with the health care system; and many and diverse community resources often exist to provide care and support to victims of spouse abuse; therefore be it

"RESOLVED, that the State Medical Society promote educational endeavors to sensitize physicians to the incidence and prevalence of spouse abuse in the Wisconsin area, to familiarize physicians with techniques that aid in the recognition of the spouse abuse victim, and to acquaint physicians with the various therapeutic and preventive resources available to spouse abuse victims; and be it further

"RESOLVED, that the State Medical Society encourage interaction among physicians, hospitals, community groups and other professional helping agencies to the end that more concerted and comprehensive approaches to the identification and ongoing care of the spouse abuse victim be adopted in the various communities of Wisconsin."

25. (Price-Taylor) Tuberculin Surveillance

Because the present regulations of the Department of Health and Social Services regarding tuberculosis surveillance in nursing homes and hospitals [H 32.05 (8) (a) (3) and H 32.07 (2) (c) (1)] were initiated many years ago; and the medical importance of a positive tuberculin skin test is currently much different than when these regulations were initiated; and the annual chest x-rays which are at times required are expensive, cumbersome and may not be medically indicated; therefore be it

"RESOLVED, that the State Medical Society request that the Department of Health and Social Services appoint an ad hoc committee including appropriate authorities representing pulmonary medicine and infectious disease to review the current tuberculosis surveillance regulations with specific attention to the cost effectiveness of required annual chest x-rays so as to determine if revised, updated regulations are in order."

26. (Section on Preventive Medicine) Preventing Exposure to Nuclear Explosions

Because the State Medical Society of Wisconsin is vitally interested in protecting and preserving life and health; and fellow physicians in virtually all parts of the world are increasingly expressing their grave concerns about the dangers of nuclear explosions; and medical resources are inadequate to care for the potential victims of one or more major nuclear explosions; and increasing the number of nuclear explosive devices increases the risk of accidental detonation; and prevention is the only effective approach available against both limited and widespread deployment of such devices, which has the potential to surpass all previous epidemics in death and injury; therefore be it

"RESOLVED, that the State Medical Society of Wisconsin announces its deep concern about the medical aspects of nuclear explosives, encourages efforts to provide reliable scientific information to the profession and the public regarding the medical consequences of nuclear explosions, and requests our public and professional representatives at the state, national and international levels to take whatever carefully considered steps are necessary to reduce the likelihood of nuclear explosions."

27. (Milwaukee) Artificial Insemination

Because nationwide attention is focused on Wisconsin as the result of a Milwaukee physician having artificially inseminated an unwed female who after insemination applied for welfare benefits; therefore be it

"RESOLVED, that the State Medical Society of Wisconsin prepare policy guidelines addressing the procedure of artificial insemination."

28. (Milwaukee) AMA Leadership Positions

Because the State Medical Society of Wisconsin has a number of members who are outstanding medical statesmen; and there has been little visible effort to promote Wisconsin physicians for significant national leadership positions in recent years; therefore be it

"RESOLVED, that the State Medical Society play a more dynamic role in identifying, recruiting and promoting its own members for leadership positions in the AMA."

29. (Basilio F Lopez, MD, Physical Medicine and Rehabilitation) Employment of Physical Therapists

Because some physical therapists in Wisconsin and other states have proclaimed publicly and through their association newsletters that any physician who employs a physical therapist is acting unprofessionally, and that a physical therapist should not work for a physician; and physical therapists are seeking changes which would eliminate and make illegal any such employment relationships; therefore be it

"RESOLVED, that the State Medical Society of Wisconsin oppose efforts to make existing employment relationship illegal between physical therapists and physicians because such relationships have historically operated to protect patients by providing them with high quality care as prescribed and monitored by physicians."

30. (DeLore Williams, MD, Delegate, Milwaukee County) Guidelines for Fairness in Competition

Because competition is an inherent element of the medical practice environment; and competition is increasing in force and dimension; and in the interest of cost containment, the federal government has adopted a policy of competition enhancement; and a natural effect of competition in the medical practice environment is a shift in physician behavior from professional conduct to business practices; and professional behavior, ethical con-

duct and fair play are essential to the preservation of medicine as a profession; and a clearly stated collection of principles and guidelines is needed to govern the conduct of physicians in competition; therefore be it

"RESOLVED, that the following guidelines be adopted by the physicians of Wisconsin as a code of conduct in the presence of competition; and be it further

"RESOLVED, that these guidelines be submitted to the AMA House of Delegates for study and possible adoption as national guidelines." (Guidelines available upon request from SMS offices)

31. (Committee on Federal Legislation) Voluntary Health Planning

Because HR 4554 which proposes the repeal of the Federal Health Planning Act has been introduced in the US House of Representatives; and the 1981 Federal Budget Reconciliation Act (PL 97-35) has significantly reduced federal financial authorization for the planning system due to the ineffectiveness of the program; and the Budget Act also allows governors to petition the US Secretary of Health and Human Services for the elimination of federal designation and Health System Agency funding; and the American Medical Association at its 1980 Interim Meeting adopted a resolution calling for the repeal of PL 93-641 and suggested the creation of voluntary, locally-based health planning; therefore be it

"RESOLVED, that the House of Delegates of the State Medical Society endorse HR 4554 and communicate that position to the Wisconsin Congressional Delegation and the AMA; and be it further

"RESOLVED, that the State Medical Society of Wisconsin advise the Governor of Wisconsin that the current planning system has been unworkable, ineffective, costly, and beyond repair, and should be abandoned in favor of a local voluntary planning system that includes adequate physician input and participation."

32. (Committee on Federal Legislation) Federal Trade Commission

Because at least 161 members of the United States House of Representatives have co-sponsored HR 3722 relative to the Federal Trade Commission, and 6 members of the Senate have introduced S 1984 on the same subject; and HR 3722 would place a moratorium on Federal Trade Commission actions against the activities of state regulated professions unless Congress specifically authorizes such an investigation and subsequent actions, and S 1984 would exempt state-regulated professions from FTC jurisdiction; and professions including the practice of medicine are already regulated in a substantial fashion by the Wisconsin Legislature via the Department of Regulation and Licensing; and the regulation of professions properly belongs with the individual states as represented by state legislatures to insure adequate professional and consumer input; therefore be it

"RESOLVED, that the House of Delegates of the State Medical Society of Wisconsin endorse the intent of both HR 3722 and S 1984 and direct the Society to continue to offer comments and support on behalf of both bills; and be it further

"RESOLVED, that this position be submitted to the Wisconsin Congressional Delegation as soon as possible."

33. (Committee on Federal Legislation) "Comprehensive Smoking Prevention Education Act"

Because the "Comprehensive Smoking Prevention Education Act" has been introduced in the United States Senate as S 1929 by Senator Orin Hatch of Utah; and S 1929 would require the Secretary of Health and Human Services to establish and execute a program designed to educate the public on the dangers to health from cigarette smoking; and the legislation identifies smoking as the largest preventable cause of illness and premature death in the United States, and that federal, state, and private initiatives have been insufficient in conveying that information to the American public; and S 1929 would require stronger health warnings on cigarette packages and advertisements as well as a disclosure of tar, nicotine, and carbon monoxide levels; and the State Medical Society of Wisconsin has adopted previous resolutions and policies regarding smoking, smoking in public places, and the dangers of smoking; and the federal government through its budgetary and tax policies actively subsidizes the production of tobacco and tobacco products while at the same time it also attempts to educate the public as to the health hazards of tobacco; therefore be it

"RESOLVED, that the House of Delegates of the State Medical Society of Wisconsin strongly endorse the passage of S 1929 and the warning and disclosure requirements of the bill; and be it further

"RESOLVED, that the State Medical Society communicate this position to the Wisconsin Congressional Delegation along with a recommendation that S 1929 and similar proposals, if any, be amended to require the elimination of all federal tobacco subsidies."

34. (Commission on Governmental Affairs) Smoking and "Clean Indoor Air Act"

Because the House of Delegates of the State Medical Society of Wisconsin has banned smoking during official meetings of the Society; and Federal legislation has identified smoking as the primary cause of lung cancer and emphysema, that one-third of deaths attributable to heart disease are associated with smoking, and that the health risks for pregnant women who smoke and their children are higher than for those who do not smoke; and the State Medical Society of Wisconsin has in the past undertaken efforts to advise Wisconsin citizens of the dangers of smoking; therefore be it

"RESOLVED, that the House of Delegates of the State Medical Society of Wisconsin reaffirms its ban on smoking during official Society meetings; and be it further

"RESOLVED, that the State Medical Society strongly endorses the intent and provisions of the "Clean Indoor Air Act" now pending in the Wisconsin Legislature which would regulate smoking in public places."

35. (Physicians Alliance Commission) The "New Federalism"

Because the President of the United States has announced plans for a "new federalism" whereby states would obtain greater "flexibility" in the administration of federal social services programs; and this approach may involve federal assumption of the Medical Assistance Program and state assumption of food stamp and AFDC programs; and the Governor of Wisconsin has publicly

offered Wisconsin as a "testing ground" for this aspect of new federalism; and such a change may result in a national standardization of medical assistance rules and provider reimbursement that are inferior to the Wisconsin Medical Assistance Program; and federal assumption may severely limit provider input into the rules, regulations, and standards of medical assistance as well as create a national "super rule" and a "lowest available" rate of reimbursement to providers; therefore be it

"RESOLVED, that the House of Delegates of the State Medical Society of Wisconsin express its opposition to the "new federalism" as it applies to medical assistance until such time as the President clearly outlines plans for the extent, both financial and regulatory, of federal "assumption" of Medicaid; and be it further

"RESOLVED, that the State Medical Society caution and urge the Governor of Wisconsin to withhold endorsement of this assumption of Medicaid by the federal government until such time as the true impact is known to all Wisconsin citizens."

36. (Physicians Alliance Commission) Physician Reimbursement

Because Blue Cross-Blue Shield United of Wisconsin and other third party insurors market health insurance policies in Wisconsin and suggest that such policies will provide reimbursement to a potential subscriber's physician via customary, usual, and reasonable fees; and Blue Cross-Blue Shield United of Wisconsin and other third party payors fail to adequately inform subscribers that the UCR determinations are made by the insuror; and physician fees are properly established by physicians themselves and the provision of medical care exists as one aspect of the physician-patient relationship; and Blue Cross-Blue Shield United of Wisconsin and other third party insurors have exerted direct interference in that relationship by misleading communications to subscribers that suggest physicians have established charges that are excessive, unwarranted, and that the subscriber, by virtue of an insurance contract is not liable for charges for medical care; therefore be it

"RESOLVED, that the House of Delegates of the State Medical Society of Wisconsin condemns actions by Blue Cross-Blue Shield United and other third party insurors that interfere with both the physician-patient relationship and the right of physicians to establish their own fees; and be it further

"RESOLVED, that Blue Cross-Blue Shield United and other third party insurors cease the issuance of letters and other communications that mislead subscribers by suggesting that patients have no legal responsibility for their medical care; and be it further

"RESOLVED, that Blue Cross-Blue Shield United and other third party insurors clearly inform potential subscribers that policies issued by the company pay claims for medical care according to rates determined by the insuror and not the individual physician; and be it further

"RESOLVED, that the State Medical Society undertake programs and efforts to inform Wisconsin citizens that health insurance policies that include insuror determined UCR are not 'total' coverage policies as promoted by the insurors." ■

State Medical Society of Wisconsin

House of Delegates—1982

Speaker—Duane W Taebel
Vice Speaker—Chesley P Erwin

County Medical Society	Delegate	Alternate
	FIRST DISTRICT	
KENOSHA	Douglas G Devan	Meredith C Clubb
	Clifton E Peterson	Mariano F deGuzman
	Joyce A Yerex	William J Jeranek
MILWAUKEE	Thomas E Dehn	Christopher J Drayna
	Paul A Dudenhoefer	Stuart L Goldman
	William E Finlayson	Ronald E Grossman
	George F Flynn	Lawrence S Larson
	Harry R Foerster, Jr	James E Lichty
	Jerome W Fons, Jr	Gregory M Nierengarten
	Glenn H Franke	Eugene P Sinclair
	Lucille B Glicklich	Jeffrey M Weber
	Marvin Glicklich	
	S Fredric Horwitz	
	Michael T Jaekels	
	Thomas M Kidder	
	Stanley A Korducki	
	Charles W Landis	
	Roger E Laubenheimer	
MILWAUKEE	Robert F Madden	
	James A Means III	
	Stephen M Mintz	
	Dean D Miller	
	John P Mullooly	
	Archebald R Pequet	
	Roger L Ruehl	
	Shimpei Sakaguchi	
	Kendall E Sauter	
	Kenneth M Smigielski	
	William L Treacy	
	Frank H Urban	
	Wess R Vogt	
	Harry F Weisberg	
	DeLore Williams	
	Walter J Woloschek	
	Carol E Young	
	Raymond C Zastrow	

County Medical Society	Delegate	Alternate
OZAUKEE	Ted D Elbe	Robert A Pfeffer
RACINE	E Paul Gander	Robert G Anderson
	Marvin G. Parker	Donald R Burke
	Huron L Ericson	Charles H Patton
	Jerome J Veranth	Raymond E Skupniewicz
WALWORTH	Irwin J Bruhn	Rocco S Galgano
WASHINGTON	Charles S Geiger, Jr	William J Listwan
WAUKESHA	John S. Blackwood	Steven W Birkholz
	Ronald J Darling	Robert C Feulner
	John A Harris	Gerald L Harned
	Charles E Holmburg	Michael G O'Mara
	G Daniel Miller	Mark J Popp
	John D Riesch	James A Stadler II

SECOND DISTRICT

COLUMBIA-MARQUETTE-ADAMS	Robert T Cooney	Martin L Janssen
DANE	Milfred A Cunningham	Charles J Anderson
	Alfred D Dally	Thomas J Ansfield
	Klaus D Diem	Robert P J Christmann
	Peter L Eichman	Robert L Cole
	Charles H Geppert	Paul F Dvorak
	William L Kopp	William J McAweeney
	Richard D Lindgren	Paul A McLeod
	Howard S Lubar	John M Nelson
	Charles H Mann	Anthony J Richtsmeier
	Bernard F Micke	Joseph F Sackett
	David L Nelson	William R Scheibel
	Sandra L Osborn	Phillip J Schoenbeck
	John K Scott	Benton C Taylor
	David W Semian	A Paul Vastola
	Robert B Shapiro	Richard O Welnick
	Richard W. Shropshire	Gary Woroch
DODGE	Norman J Schroeder II	M Ahmad Ali
GRANT	Glenn C Hillery	Leo E Becher
GREEN	Melvin S Blumenthal	Jan E Erlandson
	Vacancy	Vacancy
IOWA	Harald P L Breier	Timothy A Correll
JEFFERSON	Roland R Liebenow	George L Gay, Jr
LAFAYETTE	Vacancy	Vacancy
RICHLAND	James J Tydrich	Robert P Smith
ROCK	William N Brandt	Edward P Onderak
	Jordon Frank	William H Pollard
	Marshall F Purdy	William P West
SAUK	John A DeGiovanni	Donald W Vangor

THIRD DISTRICT

CRAWFORD	Eli M Dessloch	William N Calkins
JUNEAU	Vernon M Griffin	Jack Strong
LA CROSSE	James T Murphy	Karl P Grill
	David L Nelson	Thomas P Lathrop
	Kermit L Newcomer	Jack M Lockhart
	Stephen B Webster	Paul S Shultz
MONROE	Rolando R Buan	K M Narasimhan
TREMPEALEAU-JACKSON-BUFFALO	W Bradford Martin	Robert J Miller
VERNON	Robert A Starr	Thomas E Boston

FOURTH DISTRICT

CLARK	Bahri O Gungor	Reganti V Reddy
FOREST	Burton S Rathert	Enzo F Castaldo
LANGLADE	James O Moermond, Jr	Theodore C Fox
LINCOLN	James S Janowiak	Jerome S Mayersak
MARATHON	Francis C Johnson	Wolfram G Locher
	James D Kramer	Thomas O Miller
	J Garry Sack	William O Miller
ONEIDA-VILAS	Ismail N Nevin	Fred W Fletcher
	William F Raduege	Benn A Haynes
PORTAGE	Robert J Jaeger	Donald L Brick
PRICE-TAYLOR	James G Sargeant	Walther W Meyer
WOOD	Raymond L Hansen	Philip M Green
	Michael P Mehr	John P Milbauer
	John E Thompson	John W Schaller
	Richard H Ulmer	Charles C Sorensen

FIFTH DISTRICT

CALUMET	Julio C DeArteaga	James H Glenn
FOND DU LAC	Kenneth A Stormo	Russell S Pelton
	David R Weber	Elizabeth T Sanfelippo
GREEN LAKE-WAUSHARA	John C Koch	Roger A Kjentvet
OUTAGAMIE	Jack K Burr	Charles F Dungar
	Paul M Cunningham	Bruce A Heyl
	John S Harris	Robert R Kinde
	Thomas W Tatlock	John E Lindstrom
WAUPACA	Lloyd P Maasch	John H Steiner
WINNEBAGO	James L Basiliere	George W Arndt
	Roy E Buck	Edwin L Downing
	Charles R Lyons	Johan A Mathison
	Kenneth M Viste, Jr	Eric B Wilson

SIXTH DISTRICT

BROWN	Bruce C Bressler	Peter A Fergus
	David P Donarsky	Jay J Kuritz
	Stephen D Hathway	Herbert F Sandmire
	Robert T Schmidt, Jr	Sally M Schlise
	William F Schneider	Fred H Walbrun
DOOR-KEWAUNEE	John J Beck	Walter S Hobson
MANITOWOC	David D Pfaffenbach	Edward J Barylak
	Gary A Schmidt	Steven D Driggers
MARINETTE-FLORENCE	John F Kraus	Burnell D Stripling
OCONTO	Kenneth L Strebe	John S Honish
SHAWANO	Ronald L Logemann	John J Albright
SHEBOYGAN	Robert A Keller	Vytas K Kerpe
	Stephen C Westcott	James R Pawlak

SEVENTH DISTRICT

BARRON-WASHBURN-BURNETT	Donald E Riemer	James F Maser
CHIPPEWA	Merne W Asplund	John J Sazama
EAU CLAIRE-DUNN-PEPIN	Thomas E Pederson	Steven G Brown
	Karl E Walter	George E Owen
	James E Willard	John B Young
PIERCE-ST. CROIX	David M Woeste	Joseph E Powell
POLK	Marwood E Wegner	John O Simenstad
RUSK	Raymond R Johnson	Richard G Nash

EIGHTH DISTRICT

ASHLAND-BAYFIELD-IRON	Arlyn A Koeller	John C Oujiri
DOUGLAS	Clarence M Scott	Thomas J Doyle
SAWYER	Lloyd M Baertsch	Paul Strapon III

SPECIALTY SECTIONS

Section	Delegates	Alternates
Allergy & Clinical Immunology	Martin Z Fruchtman	John J Ouellette
Anesthesiology	Warren J Holtey	James J Brill
Dermatology	Joel E Taxman	Nyles R Eskritt
Emergency Medicine	Herbert F Laufenberg	Gary L Gerschke
Family Physicians	Robert F Purtell, Jr	John O Grade
Internal Medicine	Joseph J Mazza	Philip J Dougherty
Medical Faculties	Mark J Ciccantelli	Manucher J Javid
Medical Students	Timothy Roddy	William Armington
Neurology	Michael P McQuillen	Vacancy
Neurosurgery	Werner E Langheim	Allan B Levin
Obstetrics-Gynecology	William E Martens	Robert P Reik
Ophthalmology	John L Sella	W James Foster
Orthopedics	Paul A Jacobs	David D Mellencamp
Otolaryngology	Thomas W Grossman	Glenn M Seager
Pathology	Edward A Burg, Jr	Robert E Carlovsky
Pediatrics	Curtis R Weatherhogg	Carl S L Eisenberg
Physical Medicine & Rehabilitation	William J LaJoie	Sridhar V Vasudevan
Plastic Surgery	Vaughn Demergian	Vacancy
Preventive Medicine	Richard W Biek	Paul R Ebling
Psychiatry	William W Wood	Fred H Koenecke, Jr
Radiology	Loren E Hart	Bruce C Kirkham
Resident Physicians	Vacancy	Kay E Jewell
Surgery	J David Lewis	Louis C Bernhardt
Urology	Stuart W Fine	Clyde C Lawnicki

MEMBERSHIP UPDATE

The following physicians, by county medical society, have recently been elected to membership, or have been reelected or reinstated since publication of the Membership Directory in the January issue of the *Wisconsin Medical Journal,* with the specialty abbreviated above the name:

CHIPPEWA

IM
Harrison, Les
2501 County Trunk I
Chippewa Falls WI 54729

IM
Paulson, Steven Q
2501 County Trunk I
Chippewa Falls WI 54729

DANE

PM
Alsentzer, Ulrich K
1301 Nishishin Trail
Monona WI 53716

Blake, Donna Jo
6101 Eagle Heights
Madison WI 53705

Bohn, Michael J
602 Sawyer Terr, #125
Madison WI 53705

Decker, Ruth
1602 Fordem Ave, #117
Madison WI 53704

Emanuel, Peter D
4833 Sheboygan Ave, #332
Madison WI 53705

Espinosa, Andrea
350 Russell St
Madison WI 53704

Fennema, Karen
2309 Sommers Ave
Madison WI 53704

P
Getto, Carl J
CSC, B6/258
600 Highland Ave
Madison WI 53792

Gundlach, Timothy E
143 N Butler, #2
Madison WI 53703

P
Hodulik, Charles J
202 South Park St
Madison WI 53715

Keller, Daniel A
134 N Orchard, #2
Madison WI 53715

PD
Kindig, David A
610 Walnut St, Rm 707
Madison WI 53706

Lampsa, Diana J
1414 Jenifer St
Madison WI 53703

Manlove, Jeffrey C
933 West Johnson St
Madison WI 53715

Manske, Michael G
725 W Washington Ave, #107
Madison WI 53715

Musolf, Karen L
2801 Monroe St, #2E
Madison WI 53711

EM IM
Olsky, Mark
309 W Washington Ave
Madison WI 53703

PM
Rao, S Noel
1010 N Westfield Rd
Madison WI 53717

Rhude, David J
1424 Rutledge St
Madison WI 53703

Rowe, Mary G
7409 Farmington Way
Madison WI 53717

P
Salinger, Robert J
302 Arcadia Dr
Madison WI 53717

Schmeling, Gregory J
438 Moorland Rd
Madison WI 53713

Schroeder, Martin J
702L Eagle Heights
Madison WI 53705

Schultz, Timothy K
1810 Fordem Ave, #14
Madison WI 53704

Sonderman, Philip L
1810 Fordem Ave, #14
Madison WI 53704

FP
Stiegler, Paul M
2604 Arbor Dr, #231
Madison WI 53711

Sullivan, Shannon
1164 Emerald, #4
Madison WI 53715

FP
Washburn, Walter L
5714 Odana Rd
Madison WI 53719

Wick Kathleen M
2130 University Ave, #123
Madison WI 53705

Wittchow, Richard J
912 Fahrenbrook Ct
Madison WI 53715

DOOR-KEWAUNEE

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Sturgeon Bay WI 54235

EAU CLAIRE-DUNN-PEPIN

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Jones, Daniel L
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Eau Claire WI 54701

FP
Raymond, Lou A
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Eau Claire WI 54701

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R
Mauthe, Howard
481 East Division St
Fond du Lac WI 54935

GREEN

IM ON
Block, Margaret
1515 10th St
Monroe WI 53566

IOWA

FP
Kaiser, Cathryn I
Hollandale WI 53544

KENOSHA

PD
Cetta, Nicholas M
3618 Eighth Ave
Kenosha WI 53142

EM
Joshipura, Premal M
11921 45th Ave
Kenosha WI 53140

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Onalaska WI 54650

NS
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OPH
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La Crosse WI 54601

MANITOWOC

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P N
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OPH
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Diktas, Mustafa K
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Milwaukee WI 53223

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Milwaukee WI 53202

PD N
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Milwaukee WI 53226

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Milwaukee WI 53226

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Milwaukee WI 53204

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3039 North Hackett
Milwaukee WI 53211

Sarge, Terence J
3817 North 76th St, #3
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3510 West Burnham
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Wauwatosa WI 53222

Warpinski, Luke T
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Milwaukee WI 53214

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IM
Nelson, Carrie Jo
Eau Galle & Spruce
Elmwood WI 54720

FP
Olson, David L
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New Richmond WI 54017

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P CHP
Drom, Robert E
1244 S Wisconsin Ave
Racine WI 53403

PM
Gonzales, Michael F
3803 Spring St
Racine WI 53405

N
Park, Byung H
312 7th St
Racine WI 53403

SAUK

ORS
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Baraboo WI 53913

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Connell, Thomas R
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Sheboygan WI 53081

IM GP
Crawford III, William C
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Sheboygan WI 53081

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Jackson WI 53037

FP
Drimalla, Richard B
N168 W20060 Main St
PO Box 37
Jackson WI 53037

FP
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West Bend WI 53095

WAUKESHA

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Waukesha WI 53186

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Sheehy, Patrick G
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Marshfield WI 54449

PD PDC
Sutton, Thomas M
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Marshfield WI 54449

PM
Varia, Panna V
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Marshfield WI 54449

P
Varia, Virendra J
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Yambert, Jens
1000 North Oak Ave
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MILWAUKEE: The Medical Society of Milwaukee County honored two of its members during the Society's recent 135th Annual Meeting. Charles W Landis, MD,* Elm Grove, was honored as outgoing president of the Society, and Derward Lepley Jr, MD,* Elm Grove, received the Medical Society's Distinguished Service Award. Doctor Lepley was the chief surgeon in the surgical team at St Luke's Hospital where the first heart transplant operation in Wisconsin was performed in 1968.

SHEBOYGAN: Forty-three members and four guests were present at the February meeting of the Sheboygan County Medical Society. Guest speakers included Sydney E Johnson, MD,* Marshfield, vice president, WisPRO; David J Noll, MD,* Madison, chairman, WisPRO Quality Assurance Committee; and Donald J McIntyre, Madison, executive director of WisPRO. The topic was on WisPRO and cost containment and the following comments were made: "Patient stay review can be effective, both in improving quality of care and in reducing hospitalization cost by educating physicians. This has lead to improved physician performance by reducing unnecessary admissions, unnecessary tests, and unnecessary length of stay. Good peer review is cost-effective; peer review is now considered an indispensable part of medical practice; and PSRO may be the last chance for physician-controlled peer review. Industry is contracting for patient stay review for cost containment purposes and must have approval of hospital(s) and physicians. WisPRO is an effective physician-controlled organization."

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OUTAGAMIE: Forty-three members were present to hear guest speaker, Dan Frascella, PhD, speak on "Oral Antidiabetic Agents." New members elected to the Society are Dan L Heyerdahl, MD,* Appleton, and Jeffrey R Whiteside, MD,* Iowa City, who arrives in July. Kris Bjurstrom, field representative of the Physicians Alliance Commission, presented a life membership award to George A Behnke, MD,* Appleton, who had served as president of the State Medical Society in 1971-1972.

POLK: Twenty members were present at the February meeting of the Polk County Medical Society to hear Dr Mike Coleman, of St Paul Children's Hospital, Minnesota, speak on "Sudden Infant Death Syndrome." At the March meeting of the Society held in St Croix Falls, Paul Jacobson, field representative of the Physicians Alliance Commission, spoke on "Chiropractic Legislation" as 11 members were present. Timothy Peterson, MD,* Frederic, was elected to membership to the Society.

WINNEBAGO: Forty-four members and two guests were present at the Winnebago County Medical Society February meeting to hear H Myron Kauffman, MD,* Milwaukee. Doctor Kauffman presented a paper on "Renal Transplantation."

WINNEBAGO: At the March meeting of the Winnebago County Medical Society, the guest speaker was Lynn A Phelps, MD,* Madison. The topic was Hypnosis. Membership was approved for Paul B Christianson, MD* formerly of Trempealeau-Jackson-Buffalo County Medical Society. There were 37 members and three guests at the meeting. ■

* * *

Starting Your Practice Workshop. At least one "Starting Your Practice Workshop" will be conducted by the AMA at the headquarters building in Chicago each month this year. The two-day sessions cover money management, legal concerns, office locations, personnel management, patient relations, and medical records. Fees for the workshops are $150 for members of the AMA, state or county medical societies and $185 for nonmembers. Spouses may attend for $35. "Starting Your Practice Workshops" also are held in other locations. For information on registration or on workshops in other areas, contact Dept of Practice Management, AMA Headquarters, (312) 751-6667. ■

Obituaries

Robert P Lyons, MD, 65, Milton, died Jan 10, 1982 in Milton. Born Apr 17, 1916 in Chicago, Ill, Doctor Lyons graduated from the Loyola University School of Medicine Chicago, and completed his residency at Huntington Memorial Hospital, Pasadena, Calif, and at the California Institute of Technology. He served with the United States Navy from 1943-1947 during World War II. He was a member of the Rock County Medical Society, State Medical Society of Wisconsin, and the American Medical Association. Surviving are his widow, Colette; three daughters, Ellen, Mary, and Angela, all at home; five sons, Robert, Forest Park, Ill; John, Avenel, NJ; David, Greg, and Steve at home.

Clifford Anderson, MD, 65, Racine, died Jan 13, 1982 in Racine. Born Jan 12, 1917 in Minneapolis, Minn, Doctor Anderson graduated from the University of Oregon School of Medicine in 1944 and served his internship at the United States Marine Hospital on Staten Island, NY. His residency was completed at the University of Oregon Health Center in Portland. Doctor Anderson served in the United States Army at Fort Dix, NJ, and Fort Sam Houston in San Antonio, Tex. He was in private practice and then received a master's degree in public health in 1960 from Harvard University. Doctor Anderson had been a health officer for 10 years in the states of Washington and Oregon. Prior to becoming Racine's public health director in 1980, he had been a staff physician with the US Veterans Administration in Roseburg, Ore. He was a member of the Racine County Medical Society, State Medical Society of Wisconsin, and the American Medical Association. Surviving is his widow, Sybil of Racine.

Joseph D "Deke" Farrington, MD, 73, former Minocqua physician, died Jan 20, 1982 in Marathon Key, Fla. Born Jan 16, 1909 in Portsmouth, Va, he graduated from Rush Medical College, Chicago, Ill, and served his internship and residency at Ravenswood Hospital in Chicago. He was chief of orthopedic surgery at Ravenswood and also was on the faculty of Rush Medical College from 1932-1957. He served in the United States Army Medical Corps from 1942-1945. From 1966-1972, Doctor Farrington was a consultant of orthopedic surgery at Lakeland Memorial Hospital in Woodruff; and in July 1980, the Rehabilitative Service Department of Howard Young Medical Center was dedicated as J D Farrington Hall. He founded the Department of Orthopedics at Howard Young Medical Center. Doctor Farrington retired from active medical practice in 1972. He was editor emeritus of the *EMT Journal,* on the board of directors of the Journal, and wrote the textbook "Emergency Care and Transportation of the Acutely Ill and Injured," the leading textbook in training ambulance attendants. He was a member of the American Academy of Orthopedic Surgeons, the American Association for Surgery and Trauma (president 1976), the American College of Surgeons, and the American Medical Trauma Society. He also was a member of Oneida-Vilas County Medical Society, State Medical Society of Wisconsin, and the American Medical Association. Upon retirement to Key Colony Beach, Fla, he became a Trustee of Fishermen's Hospital and later served as president of the Board. Surviving are his widow, Sonja; two sons, Dr Frank, Richmond, Va, and David of Bethesda, Md.

Charles H Shields Jr, MD, 59, Fennimore, died Jan 27, 1982 in Dubuque, Iowa. Born May 20, 1922 in Decatur, Ill, Doctor Shields graduated from the University of Cincinnati Medical School in 1951 and completed his internship at St Mary's Hospital in Madison. Doctor Shields served in the United States Army during World War II from 1943 to 1946. He had practiced medicine in Fennimore since 1952. He was a member of the American Academy of Family Physicians, Grant County Medical Society, State Medical Society of Wisconsin, and the American Medical Association. Surviving are his widow, Susan; a son, Mike, Story City, Ia; and a daughter, Mrs Jerry (Sandra) Waldman of Stitzer.

Leland Charles Dietsch, MD, 85, Plymouth, died Feb 4, 1982 in Sheboygan. Born July 13, 1896, in Plymouth, Doctor Dietsch graduated from Rush Medical College, Chicago, and completed his internship at Evanston Hospital in Illinois. He served in the United States Army during World War I. Doctor Dietsch had practiced medicine in the Plymouth area for 41 years before his retirement in 1968. Surviving are his widow, Marjorie, and one daughter, Mrs Bradford (MargieLee) Hait, Palos Verde, Calif.

Earl J Sullivan, MD, 57, Monroe, died Feb 21, 1982 in Little Rock, Arkansas. Born Mar 16, 1924 in Madison, Doctor Sullivan graduated from Marquette University School of Medicine in 1949 and served his internship at St Joseph's Hospital, Marshfield. His residency was completed at South Bend Medical Foundation, South Bend, Ind. A pathologist, Doctor Sullivan had practiced in Johnson City, Tenn, and Fond du Lac, Wis. Surviving is his widow, Grace. ■

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SMS introduces legislation to reform public health system

Two legislative proposals which would dramatically alter the administration and funding for public health services in Wisconsin were introduced in the State Assembly March 4 at the request of the State Medical Society of Wisconsin.

The first of two bills introduced by Rep Richard Flintrop (D-Oshkosh) calls for creating a new Division of Public Health within the Dept of Health and Social Services which would consolidate health functions now performed by four other state departments. A health professional trained in public health administration would head the new division and would direct activities for community health, environmental health, and mental health programs for the state.

Furthermore, a Division of Health Regulation and Financing would be established to handle programs relating to Certificate of Need administration, Medical Assistance, health planning and development, and regulation of home health care agencies.

"The people of this state deserve and need a 'full-service' public health system," Rep Flintrop said.

"With Medicaid and health regulation dominating the attention of the Division of Health Administrator at the expense of public health, it seems administratively wise for these areas to have separate administrators. In that manner, we can be assured that public health programs are not raided every time the state needs additional money to support an ever-growing Medicaid budget," he said.

The Departmental Reorganization Bill would direct the Legislative Council to study the feasibility of consolidating within the new Public Health Division all health-related activities of state government.

Rep Flintrop, citing a Report on Public Health which the State Medical Society of Wisconsin prepared and forwarded to the Governor in 1980, said the low priority given to public health in recent years is evidenced by 1979-81 state budget figures showing public health activities accounting for only five percent of total Dept of Health and Social Services budget dollars.

"Funding for public health has been almost totally federal and local dollars," Flintrop said. "The irony in this situation is that the poorer areas of the state, where property tax revenue is insufficient to support public health departments, usually have the greatest need for public health services," he said.

The medical society report also states that over one-half of the Wisconsin population are not served by a full-service city or county public health departments. Another legislative proposal of Rep Flintrop's, LRB-4846, would attempt to rectify this insufficiency by establishing a network of full-service local public health agencies in Wisconsin to replace numerous local agencies currently performing various levels of services.

These "community public health services boards" as they are called, would be funded by state general purpose revenue of up to $3 per capita with matching dollars from local governments.

Both of these proposed bills emanated from a paper: "The Public Health System in Wisconsin: A Report with Recommendations" prepared by an ad hoc committee of physicians of the State Medical Society of Wisconsin in July 1980. The committee was chaired by Robert Carlovsky, MD, Fond du Lac.■

LEGISLATIVE UPDATE

• T-19 Second opinions may become permanent— Senate Bill 783, the Governor's proposed Budget Adjustment Bill, contains a provision to make the Medicaid Second Opinion Program permanent. Unless extended by the Legislature, the program is scheduled for termination on June 30 of this year.

The Governor's recommendation came about as a result of a Department of Health and Social Services' report which proclaimed the program has been quite successful in saving Medicaid dollars. Most of the alleged savings were not associated with second opinions disconfirming recommended surgery, but rather the report concluded that the program's existence—with knowledge that first opinions would be reviewed—affected physician behavior in recommending surgery at all. The presumption was labeled the "sentinel effect" by the Department.

Before SB 783 passed the Senate in March, Senator Daniel Theno (R-Ashland) introduced a Medical Society amendment which called for DHSS to again study the effectiveness of the program and report those results to the Legislature prior to January 1, 1984.

The Medical Society felt DHSS' initial report relied more on "guesstimates" than verified cost savings and suggested the amendment so the program could accumulate a few more years of experience before a final decision was made to make the program permanent. The amendment was not included in the bipartisan package agreed upon by the Senate. SB 783 is now in the Assembly for consideration in that House.

• Artificial insemination unprofessional conduct— Physicians providing artificial insemination to a woman who the physician knows, or has reason to believe, is receiving AFDC or Medicaid or who will be eligible for those benefits as a direct result of the child's birth would be charged with unprofessional conduct and be subject

to disciplinary action of the Medical Examining Board under a provision contained in SB 783.

Attempts by the Medical Society to delete the provision from the agreed upon bill were unsuccessful before it passed the Senate in March.

While the Medical Society does not endorse artificial insemination for women on public assistance, it opposes the inclusion of this provision within the laws on unprofessional conduct. Unprofessional conduct laws are a means for protecting the public from illegal, incompetent, immoral or negligent behavior on the part of licensed professionals. Artificial insemination when properly performed is none of the above.

SMS argues that the SB 783 provision implies the procedure is appropriate or unprofessional depending upon the financial status of the patient. Heretofore unprofessional conduct laws protected all classes of patients on an equal basis.

Although artificial insemination is not a covered service under Medicaid, the Joint Finance Committee added this provision to the Budget Adjustment Bill to act as a further deterrent for performing the procedure on public assistance patients or on those potentially eligible. ■

DHSS issues new 'Terms of Reimbursement' for T-19

In late March the Department of Health and Social Services mailed a memorandum to all Wisconsin physicians who are certified providers in the Medical Assistance Program (T-19) regarding 1982 "Terms of Reimbursement."

In that memo DHSS states that until further notice, physicians will be paid for Medicaid services via the Medicare profile system utilizing *Medicaid* data. This is the same approach used since December 1981 when new "profiles" were implemented with a maximum allowable increase of 7.5% over 1980. DHSS by federal law is not now obligated to increase Medicaid payments every July 1st, although the December adjustment can legitimately be cited as an increase for the period July 1, 1981 to June 30, 1982. Hence, until further notice payments will remain "as is."

On or about July 1, 1982 DHSS intends to implement a new system for paying physician claims—in effect a "maximum allowable fee schedule." Prior to the implementation of that system physicians will again be notified by DHSS as to the details of that new methodology.

DHSS has asked for and SMS has appointed a special ad hoc committee to review this new methodology prior to any implementation by DHSS. ■

CES FOUNDATION

CONTRIBUTIONS—JANUARY 1982

The Charitable, Educational and Scientific Foundation of the State Medical Society is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for January 1982.

Unrestricted

Cyril M Hetsko, MD; RL Waffle, MD; DeLore Williams, MD; Alan W Babcock, MD; Robert D Heinen, MD; Maxine Gilbert; Mary Rusch; Dee Miller; Mavis O Minor; Olive Powers; Mary Cornwell; SMS Members—*Voluntary Contributions*

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Joan E Janssen—*Museum of Medical Progress Endowment Fund (Aesculapian Society)*

Michael F Ries, MD; Elizabeth A Steffan, MD; Thomas A Leonard, MD; Kenneth M Viste Jr, MD—*Beaumont 500 Club*

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Dr—Mrs EJ Nordby—*Carl A Fosmark Jr*

Dr—Mrs DN Goldstein—*Clifford M Creswell, MD*

State Medical Society—*David L Williams, MD; Alfred J Klein, MD; Frederick J Joachim, MD; Wilson S Phillips, MD; Clifford Anderson, MD; Joseph F Kovacic, MD; Alfred NE Merten, MD; Sam Salan, MD; William C Wojta, MD*

Dr-Mrs Robert T Schmidt-*Cyril Vansistine (Brown County Loan Fund)*

Dr-Mrs Donald M Rowe—*Robert W Leonhardt (Sheboygan County Fund)*

Dr-Mrs Garrett A Cooper—*Museum of Medical Progress Endowment Fund (CH Crownhart)*

Mr-Mrs Earl R Thayer—*Museum of Medical Progress Endowment Fund (Louis Eisenberg, MD)*

Physician Briefs

*Physician members of State Medical Society of Wisconsin

Ian M Ratner, MD, recently became associated with the medical staff of the Gundersen Clinic, Ltd. Doctor Ratner graduated from Dartmouth Medical School, Hanover, NH, and served his internship at Grady Memorial Hospital in Atlanta, Ga. His residency in pediatrics was completed at the University of Colorado Medical Center, Denver. Most recently he completed a fellowship in neonatology at the Children's Hospital in Denver.

P Stephen Shultz, MD,* recently was named medical director for the Skemp-Grandview-LaCrosse Clinic. He succeeds Robert L Gilbert, MD,* who retired in October 1981. Doctor Shultz has been a member of the Clinic's Department of Pediatrics since 1976. Doctor Shultz graduated from the University of Illinois Medical School and completed his residency at the CS Mott Children's Hospital, University of Michigan, Ann Arbor. He is a member of the American Academy of Medical Directors and is medical director of the LaCrosse Home for Children.

Doctor Shultz

Charles W Troup, MD,* Green Bay, has relocated his practice to the Medical Arts Building. The Green Bay native has been a specialist in the Green Bay area for ten years, practicing in pediatric and adult urology, urodynamics, infertility, micro-surgery, and prosthetics. He previously was associated with Urological Surgeons, Ltd. Doctor Troup is president-elect of the Wisconsin Urological Society and is certified by the American Board of Urology and a Fellow of the American College of Surgeons. He serves on the medical staffs of the three Green Bay private hospitals.

Charles Thurston, MD, Iola, recently began his medical practice in Iola. He graduated from the Medical College of Ohio, Toledo, and served a rotating internship at Riverside Hospital in Toledo. He previously had practiced in Marfa, Texas, and has been practicing in the emergency room of the Shawano Community Hospital since September 1981.

Leonard H Wurman, MD,* Wausau, recently addressed the Academy of Facial, Plastic, and Reconstructive Surgery in Boston, Mass. He spoke on the work he and his associates MDs John V Flannery Jr* and J Garry Sack* did using a device to externally immobilize nasal fractures. A report on the work of the three physicians will appear in the Academy's monthly journal, *The Laryngo-Scope.*

Michael T G Marra, MD,* Amery, recently was elected to the Board of Directors of Apple River Valley Memorial Hospital in Amery. A general practitioner, Doctor Marra had served on the medical staff of the hospital from the time of its opening in 1956 until his retirement in 1979. He had been in practice in Amery since 1949.

Walton D Thomas, MD,* recently was elected chairman of the board of the Milwaukee Medical Clinic. Other officers elected were MDs Eugene W Monroe, president; Edwin G Montgomery, vice-president; and Gerald J McCarthy, secretary-treasurer. Robert J Santilli, MD, was reelected as the Clinic's medical director. Charles W Bourne, MD,* also was elected to serve on the board for two years.

Andrew T Przlomski, MD,* Kenosha, recently was elected president of St Catherine's Hospital medical staff in Kenosha. Doctor Przlomski graduated from Marquette University School of Medicine, Milwaukee, and served on a rotating internship with Harbor General Hospital in Torrence, Calif. He has been in private family practice since 1971 and is associated with MDs James A Heck,* William J Jeranek,* and Michael J Rizzo in Kenosha.

Paul L Schmidt, MD, formerly of the Farrell Clinic, Prairie du Chien, has joined the medical staff of the Sun Prairie Clinic, a division of the Dean Medical Center. Doctor Schmidt graduated from the University of Missouri Medical School and completed his internship and residency at St Mary's Hospital Medical Center, Madison. Board certified in family practice, Doctor Schmidt has served as secretary of the medical staff at Memorial Hospital in Prairie du Chien Convalescent Center.

Richard O Schultz, MD,* Milwaukee, has been selected as the first recipient of the R D and Linda Peters Chair in Ophthalmology. Doctor Schultz, professor and chairman of the Medical College of Wisconsin's Department of Ophthalmology and director of the Eye Institute at Milwaukee County Medical Complex, is an expert in corneal and external diseases of the eye. He has served as a member of the board of governors of the American College of Surgeons and as a member of the executive committee of the board of directors of the American Academy of Ophthalmology. He is a past president of the Association of University Professors of Ophthalmology and is a member of the prestigious American Ophthalmological Society. The R D and Linda Peters Foundation has established a fully-endowed chair in ophthalmology at the Medical College of Wisconsin (MCW) through a commitment of $500,000. The Peters Foundation was created in 1966 by the late Raymond D Peters, an industrialist and leading community figure in Brillion and by Mrs Linda Peters who still resides in Brillion. MCW President Leonard W Cronkhite Jr, MD, called this major gift an invaluable boost both to eye care and to the college. "Doctor Schultz, who is an outstanding academic ophthalmologist, is an excellent choice for the chair," he said.

Doctor Schultz

Richard W Shropshire, MD,* Monona, recently was nominated for the office of vice speaker of the American Academy of Family Physicians, by the Wisconsin Chapter. Doctor Shropshire is a graduate of the University of Iowa Medical School and completed his internship and residency at the Washington DC General Hospital. He has been a member of the Monona Grove Clinic since 1957 except for the years 1976-1978 when he was director of the Family Practice Residency Program at the University of Wisconsin Medical School in Madison. He has served as chairman of the SMS Commission on Health Information and also as vice-president and president of the Dane County Medical Society.

Doctor Shropshire

William G Clancy, MD,* head of sports medicine at the University of Wisconsin, Madison, recently was the featured speaker at the 8th annual River Valley Blackhawk wrestling banquet. Doctor Clancy graduated from the State University of New York and served his internship and residencies at St Luke's Hospital at Columbia University in New York. He has been athletic team physician at the UW since 1974 and is an associate professor of orthopaedic surgery at the University of Wisconsin Medical School, Madison. During the 1980 Winter Olympics at Lake Placid in New York, Doctor Clancy was head medical officer for Nordic Jumping competition and also an orthopaedic consultant for the US Olympic Nordic Team and the US Hockey team.

Derward Lepley Jr, MD,* nationally known heart surgeon who led the team that performed Milwaukee's first heart transplant, recently announced that he would no longer do surgery, stating he "simply had found his normal 10-hour surgical days too tiring and now preferred to concentrate on consultation and research work." He added, however, "But I don't want anybody to spread the word I am retired. I can still use this computer upstairs for consultation and research." Doctor Lepley has always been concerned with the high costs of medical care and organized efforts to have physicians voluntarily curb healthcare spending. He is past president of the Medical Society of Milwaukee County and currently serves on its board of directors.

George R Tanner, MD,* Wausau, recently was inducted as a fellow of the American Academy of Orthopaedic Surgeons at its annual meeting held in New Orleans.

Larry P Kammholz, MD,* Oshkosh, recently was recertified by the American Board of Pediatrics. ■

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AMA Physician's Recognition Award Recipients

LISTED BELOW are those physicians in Wisconsin who have earned the AMA Physician's Recognition Award in recent months. The award was established in 1969 "to recognize, encourage and support physicians who participate regularly in continuing medical education and to emphasize the importance of developing more meaningful continuing medical education opportunities for physicians." A minimum of 150 credit hours of CME must be earned over a three-year period to qualify for the award. The hours may include such activities as conferences, residencies, teaching, writing, private reading, listening to cassettes, home study courses, consultation, and peer review; at least 60 of the hours, however, must be from formal CME programs sponsored or cosponsored by organizations accredited for these activities. The State Medical Society of Wisconsin congratulates the following physicians who have distinguished themselves and their profession by their commitment to continuing education:

FEBRUARY 1982

*Aaberg, Thomas Marshall, Elm Grove
*Ahmad, Muhammad Yusof, Merrill
*Anderson, Ashley, Madison
Avery, Pamela G, Madison
*Beeker, David L, Milwaukee
Bedi, Ashok R, Brookfield
Beresford, Thomas P, Wauwatosa
*Boyle, Robert W, Wood
*Chang, Henry Ta-Shen, Fond du Lac
*Chelius, Carl-Juergen W H, Cudahy
*Dasler, Herbert A, Amery
*Feiges, Lewis M, Milwaukee
*Fischer, Louis C, Fond du Lac
*Gehl, Gerald A, Neenah
*Hanson, Allen S, St Croix Falls
*Headlee, Raymond, Elm Grove
Heintz, Norman V, Winnebago
*Himes, Joseph, Milwaukee
Jacobi, Michael A, Manitowoc
*Keller, Francis L, Janesville
*Kloehn, Ralph A, Wauwatosa
Madsen, James, Stanley
*Markson, John W, Milwaukee
*Martin, Carroll M, Racine
*McAndrew, John B, Oshkosh
*McBeath, Andrew A, Madison
*McClung, John L, Madison
*Miller, Thomas O, Wausau
*Mork, Harold C, Oshkosh
*Mueller, Carol E, Boscobel
*Nordby, Eugene J, Madison
*Page, Robert W, Marshfield
*Pohl, Alan L, Milwaukee
Qasem Khaled A, Tomah
*Ruch, Donald M, Milwaukee
*Semler, William L, Milwaukee
*Shahbandar, Hassan, Appleton
Soifer, Morton M, Milwaukee
*Stoerker, Ruth A, Madison
*Tomkiewicz, Ralph E, Racine
*Urbanek, Robert E, Beaver Dam
*Venci, Nicolas A, Greendale
*Willson, D Maclean, Milwaukee
*Ziehl, Frank L, Milwaukee

Members of the State Medical Society of Wisconsin

CORRECTION. On page 44 of the February 1982 issue of the *Wisconsin Medical Journal*, under the November recipients of the AMA-PRA awards, there were two errors in spelling due to submission of poor copy to the WMJ. As a result the doctors also were not identified as members of the State Medical Society of Wisconsin. The correct spellings are: Stenborg, Walter P, Milwaukee; and Fisher, Albert J, La Crosse; both of whom are members of SMS. ■

ANNUAL MEETING May 14-16, Mead Inn Wisconsin Rapids

THE WISCONSIN SOCIETY of the American Association of Medical Assistants, Inc will hold its 27th Annual Meeting May 14-16, at the Mead Inn, Wisconsin Rapids. Wood Chapter will host the event with the theme "Tomorrow—A Day Away." Governor Lee Dreyfus will be issuing a Proclamation declaring May 10-16 Medical Assistants Week in Wisconsin. A similar proclamation will be issued by the city of Wisconsin Rapids.

Friday noon, May 14, a Delegates Luncheon will precede the House of Delegates where the business of the Society will be conducted including the election of new officers.

Saturday, May 15, will be devoted to educational sessions with CEUs (Continuing Education Units) being awarded to those successfully passing the examination following each presentation. President Sheila Sue Carlson will preside throughout the day.

A one-hour program on "EEG and the Medical Assistant" will be presented by Mr Jerry Berends, Registered EEG Technician at the Marshfield Clinic. A two-hour session on "Cosmetic Allergies" will be the presentation of William F Schorr, MD, Marshfield dermatologist. A one and a half hour afternoon session will deal with "Gastric Bypass Surgery" by Doctor Marvin E Kuehner, Marshfield general and vascular surgeon. A luncheon honoring Past State Presidents and Chapter Presidents will be held at noon. Membership and Publication Awards will be presented at that time.

A cocktail party will precede the formal evening banquet which will feature entertainment by the Assumption High School Swing Choir.

Sandra Doyle, CMA-C, Wisconsin Rapids, will succeed Sheila Sue Carlson, Milton, as president at an installation ceremony. The installing officer will be Barbara B Schumann, CMA-A. Wood Chapter will honor the new president with a reception following the banquet.

Sunday morning, May 16, an ecumenical church service will precede the traditional brunch where a summary of the House of Delegates will be presented and 1982-1983 committees will be introduced. An invitation to the 1983 Annual Meeting will be extended by Racine Chapter. The brunch will signal an end to the Annual Meeting and the beginning of a new year for AAMA, Inc, Wisconsin Society.

Inquiries are welcome and may be directed to the Annual Meeting co-chairmen:

Corinne Boushon, CMA
Sandra Doyle, CMA-C
929 Grove Avenue, Apt 2
Wisconsin Rapids, WI 54494
Telephone—Home: (715)424-4755
Office: (715) 423-3500 ■

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Wisconsin Orthopaedic Society has announced its new officers for year 1982-83. They are MDs Donald R Gore,* Sheboygan, president; and D Scott Sellinger,* Sheboygan, secretary-treasurer. The officers for the SMS Scientific Section on Orthopaedics are MDs Donald R Gore,* chairman; D Scott Sellinger,* secretary-treasurer; Paul A Jacobs,* Milwaukee, delegate; and David D Mellencamp,* Milwaukee, alternate delegate. Apart from a meeting in conjunction with the Annual Meeting of the State Medical Society of Wisconsin which is to be held in May in Milwaukee, the next meeting will be held on Nov 5, 1982 at the Olympia Resort in Oconomowoc.

Wisconsin Academy of Physicians' Assistants will hold its Seventh Annual WAPA Convention and CME Meeting June 17-19 at the Holidome in La Crosse. Convention theme is: *Emergency Medicine.* Fifteen CME credits can be obtained by those attending. A Hawaiian Luau is planned for Thursday night, and dinner and riverboat ride on the La Crosse Queen down the Mississippi River Friday night.

Marvin Birnbaum, MD,* University Hospitals, Madison, will speak on *Evaluation and Management of the Patient and Multiple Trauma;* Jack D Brown, MD* of the Sparta Clinic will lecture on *Diabetic Emergencies;* and Jan Idzikowski, PA-C will talk on *Meniscus Injuries of the Knee.*

Further information is available from Dan Robillard, PA-C, program chairman, at work 608/269-6731 or home 608/269-3779; or contact Bill Wendle, Executive Director, WAPA, at 608/257-6781. Mailing address: 330 East Lakeside St, PO Box 1109, Madison, WI 53701.

Wisconsin Society of Pathologists has announced its officers for the year 1982-83. They are MDs Charles P Nichols,* LaCrosse, president; Raymond C Zastrow,* Milwaukee, vice president; Gerald A Hanson,* Milwaukee, Secretary; and Robert F Lipo,* Milwaukee, treasurer. The officers for the SMS Scientific Section on Pathology are MDs Charles P Nichols,* chairman; Robert F Lipo,* Milwaukee, secretary-treasurer; Edward A Burg,* Milwaukee, delegate; and Robert E Carlovsky,* Fond du Lac, alternate delegate.

Academy of Pediatrics. The 1982 Annual Meeting of the Wisconsin Chapter of the American Academy of Pediatrics will be held May 20-23 at the Americana Resort (formerly the Playboy Club) in Lake Geneva. This year's program will focus on children and adolescents in history. Registration is $45. For further information contact Cameron Gundersen, MD, 1835 South Avenue, La Crosse, Wis 54601; phone 608/782-7300.

American College of Physicians in January adopted a position paper on direct access to specialist care in HMOs. The ACP states: In many HMOs primary care physicians must make or supervise all initial patient evaluation and determine the need for any subsequent referral to a specialist. Under such a system of patient management, patients cannot refer themselves to specialist care. The ACP maintains that a legitimate function of HMO patient management may include organizing its medical staff in such a way that limits direct access by patients to specialist care. The College also states that in order to protect the rights of patients to secure medical services and to provide for adequately informed choice among various health plans, the prospective HMO enrollees should be advised of any patient self-referral limitations and advised of the circumstances under which they can seek alternative services. Copies of the position paper can be obtained by calling or writing the ACP's Division of Public and Professional Communications, 4200 Pine St, Philadelphia, PA 19104 (TWX 710 670 0586). ■

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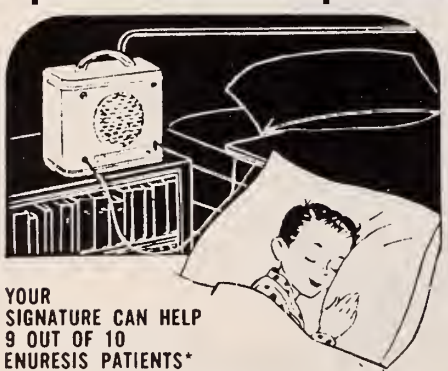

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1982 ANNUAL MEETING
STATE MEDICAL SOCIETY OF WISCONSIN
May 13–15 • Milwaukee

St Luke's Hospital Medical-Dental Staff, Milwaukee, recently elected the following physicians as officers of its staff. They are MDs John E Cordes,* Elm Grove, president; Joseph A Manago,* West Allis, secretary-treasurer; James A Rydlewicz,* New Berlin, chief of Department of Orthopedics, and Donald J Chrzan, Greendale, chief of Department of Otorhinolaryngology and Maxillofacial Surgery.

St Mary's Hospital Medical Center, Green Bay, recently elected its officers for 1982. They are MDs Paul R Bolich,* president; John J Rank, vice president; David L LeMoine (DDS), secretary; Donald L Sherwood,* chairman, Department of Family Practice/Pediatrics; Charles S Nordell,* chairman, Department of Medicine; John C Gallagher,* chairman, Department of Obstetrics-Gynecology; John H Draheim,* chairman, Department of Pathology; Roger C Wargin,* chairman, Department of Radiology; and Darel C Angus, chairman, Department of Surgery.

Lutheran Hospital Campus of Good Samaritan Medical Center, Milwaukee, recently named two Elm Grove physicians to head the medical staff. They are MDs David J LaFond,* chief of staff and William L Deardorff, vice chief of staff. Thomas J Flatley, MD,* Whitefish Bay was elected secretary. Named department chairmen were MDs William B Rabenn, Glendale, Anesthesiology; Clarence J Kocovsky,* Wauwatosa, Family Practice; Hanno H Mayer, Fox Point, Medicine; William E Martens,* Wauwatosa, Obstetrics and Gynecology; E Basil Jackson,* Menomonee Falls, Psychiatry; Charles J Locher,* Shorewood, Radiology, and Conrad M Heinzelmann,* Brookfield, Surgery. Elected members-at-large were MDs James S Ziolkowski and Roland C Brown,* both of Wauwatosa, and Eric P Conradson* of Brookfield.

Hudson Memorial Hospital, Hudson, recently began accepting patients into its new 4-bed hospice unit. Besides the four private rooms for patients, the hospice has family sleeping rooms, a kitchen where patients and families can enjoy meals together, television and library room, counseling and reception rooms, and a glass enclosed solarium that is highlighted by a stained glass window depicting a peaceful forest scene. Serving on the multidisciplinary hospice staff is Ruben Fermin, MD,* who has been named as medical director. A hospice training program is in progress at Hudson Hospital where 75 staff members, potential volunteers, clergy, and interested citizens attend classes centered around interaction with the terminally ill patient and their families. ■

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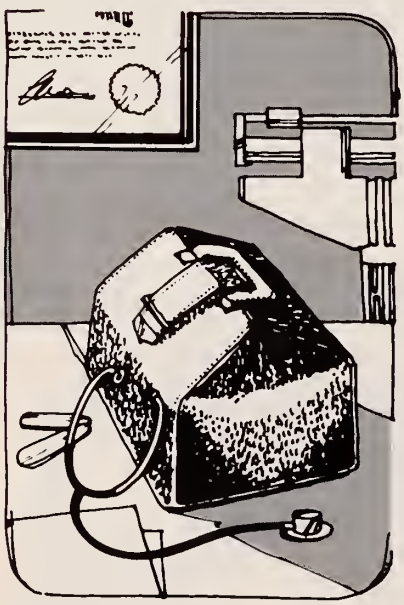
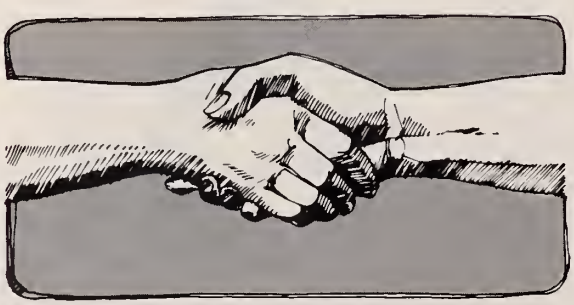


The State Medical Society of Wisconsin announces a new program designed to improve physician-patient communications and encourage greater patient feedback.

The program, entitled "Partners in Good Health," contains statement stuffers, reception area brochures, patient feedback questionaires and a certificate of participation to be displayed in the reception area.

Program brochures are available in quantity by writing to:

The Communications Department
State Medical Society of Wisconsin
P.O. Box 1109
Madison, WI 53701



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Physicians Exchange

Opportunity for qualified physicians at the Albert Lea Clinic, PA, in Albert Lea, Minnesota. The clinic is a 17-man multispecialty group in primary and secondary care fields. The financial rewards are exceptional and practice challenges very attractive. There is a negotiated salary at top level for the first year. Senior physician participation begins at the end of the first year with an incentive income distribution plan plus expanded fringe benefits. The clinic has a low cost buy-in with a maximum profit sharing plan. There is a top level insurance program, medical reimbursement program, and a full range of other benefits. A nearly new hospital in the city provides an exceptional place to work. These are choice practices in a delightful place to live. We are currently looking for physicians in general orthopedic medicine, in otolaryngology, one OB-GYN, one country family practice physician for a branch in New Richland, Minnesota, one family practice physician for the main clinic in Albert Lea; both of these positions are open now and should be filled by late 1982. An additional family practice opening will be available in mid-1983 or earlier for anyone who might be available. Please contact B J Boss, Administrator, Albert Lea Clinic, PA, 1602 Fountain St, Albert Lea, MN 56007. Phone 507/373-8251. Personal phone 507/377-1406 or contact L E Shelhamer Jr, MD, 507/373-8251 or personal phone 507/377-1530. 4/82

Wausau Medical Center, SC, a 50-physician multispecialty group has openings for physicians in the following specialties: *Family Practice, Neurology, Otolaryngology,* and *General Surgery* with a fellowship training in *Peripheral Vascular Surgery.* Competitive first-year salary, incentive plan thereafter. Comprehensive fringe benefits. New facility near new hospital. Located in beautiful, quiet, central Wisconsin, metropolitan area of 65,000. Recreational opportunities abundant. For more information contact: K L Day, MD, Wausau Medical Center, SC, 2727 Plaza Drive, Wausau, Wis 54401, or call collect 715/847-3351. 3tfn/82

Immediate opportunities for emergency medicine physicians who possess excellent clinical and communication skills to join longstanding group of Emergency Physicians. Positions available in a popular Wisconsin area bordering Illinois. If interested, send resumé to Barbara Wilcynski, Medical Emergency Service Associates (MESA), SC, 15 S McHenry Road, Suite 2, Buffalo Grove, Ill 60090; or call collect 312/459-7590. 3-4/82

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1-12/82

Faculty Member Family Practice Program. The Black Hawk Area Medical Education Foundation is recruiting a Board Certified Family Physician to join its Family Practice Residency Program in Waterloo, Iowa. The program is community-based, affiliated with the University of Iowa College of Medicine, and part of the Iowa Network of Family Practice Residency Programs. The Waterloo metropolitan area has 125,000 people, four hospitals, and is well represented in the medical specialties. Applicants should have a MD degree, be eligible for licensure in Iowa, and should have several years of practice experience. Major duties include teaching residents in all aspects of patient care, including obstetrics, and also providing patient care. Other duties include some program administration and assisting in research from time to time. A salary in the range of $60,000 per year with an additional 20% fringe benefit package is offered. Other fringe benefits relating to retirement, moving expenses, and continuing education are provided. Please submit your resume to: Charles A Waterbury, MD, Program Director, Black Hawk Area Medical Education Foundation, 441 East San Marnan Dr, Waterloo, Iowa 50702; ph (319) 234-4419. Equal Opportunity Employer. 1-4/82

The Nicolet Clinic, SC, a young progressive 38-physician multispecialty group, has superb opportunities available for the practice of *General Surgery, Neurology,* and *Radiology.* Ideal family oriented community in metropolitan area with excellent schools, economy, culture and recreation for all four seasons. Located on northern Lake Winnebago. First year negotiable salary with option for full membership at nine months. Adjacent to modern regional hospital. Excellent benefits in addition to qualified profit-sharing plan and support for continued education. Contact in confidence: Curtis C Baltz, MD, Nicolet Clinic, SC, 411 Lincoln St, Neenah, Wis 54956; ph 414/727-4244. 3-6/82

OB/GYN Specialists. Enjoy the security of group practice with the freedom of independent practice. If you are Board Certified or Board Eligible in OB/GYN, we have an interesting opportunity for you. Two specialists are needed immediately to form an independent OB/GYN practice in a very desirable Northern Wisconsin community with a drawing population of 70,000. Active practice assured. All major specialists available for consultation. Business and technical advice will be provided. Outstanding personal benefit programs available. Good income potential. New 35 million dollar hospital. For further information write: Administrator, PO Box 1646, Wausau, Wisconsin 54401. 2-4/82

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Physicians Exchange

continued

Wanted. Board certified or eligible orthopedic surgeon to practice in conjunction with a 5-member surgery department in a 22-member multispecialty group. Present surgical specialties: thoracic and vascular surgery, general surgery and urology. The group is located in the upper midwest, in a city of 100,000 between two major metropolitan areas of greater than one million. If interested, please send CV to: Stephen Wagner, Kurten Medical Group, SC, 2405 Northwestern Ave, Racine, Wis 53404. All inquiries will be kept confidential. 12tfn/80

General Surgeon. Board eligible/certified to join primary care group of six family physicians. Well established, rural setting, preceptor University of Wisconsin, JCAH 70-bed hospital. Send CV to: Gary Petersen, MD, Krohn Clinic, Ltd, 610 W Adams St, Black River Falls, Wis 54615. 10 tfn/81

Dermatologist, Rheumatologist, Family Practitioner needed to join multispecialty group of 33 physicians dedicated to primary care in East Central Wisconsin community. City population 48,000, drawing area 100,000. Attractive income arrangements, association membership possible after one year, pension and profit sharing, extensive fringe benefits. Contact R B Windsor, MD, 1011 North 8th St, Sheboygan, Wis 53081; ph 414/457-4461. 4tfn/82

Family Practice and Urology positions available with an 18-member multispecialty group corporate practice. Modern clinic facility in Northeastern Wisconsin city of 100,000 enjoying a healthy and stable economy. Excellent recreational, educational, hospital, civic advantages. Please call collect or write: W J Mommaerts, Clinic Manager, West Side Clinic, SC, 1551 Dousman St, Green Bay, WI 54303; ph 414/494-5611. 1-4/82

Fifty-physician, multi-specialty clinic in west central Wisconsin wants neonatologist, neurologist, neurosurgeon, orthopedic surgeon, and otolaryngologist. Excellent cultural, educational, and recreational facilities. 90 miles from Minneapolis. Please contact James R Jepson, Administrator, Midelfort Clinic, Ltd, 733 West Clairemont Ave, Eau Claire, Wis 54702; or call 715/839-5266. 2-4/82

General and Vascular Surgeon. Board eligible/certified to join 9-man multispecialty group in Southeastern Wisconsin. Well established, recreational setting. Adjacent to 150-bed hospital. Send CV to Administrator, Burlington Medical Center, 190 Gardner Ave, Burlington, Wis 53105. p3-5/82

Internist wanted. Board certified or eligible with/without subspecialty, to practice in conjunction with a 6-member Internal Medicine Department in a 22-member multispecialty group. Present subspecialties: Gastroenterology and cardiology. The group is in Southeastern Wisconsin, in a city of 100,000 between two major metropolitan areas of greater than one million. If interested, please send CV to: Stephen L Wagner, Kurten Medical Group, 2405 Northwestern Ave, Racine, Wis 53404. All inquiries will be kept confidential. 3tfn/82

PUT EXPERIENCE TO WORK FOR YOU WHILE YOU SEARCH FOR A NEW CHALLENGE

Let years of experience as a healthcare professional and a Placement Counselor assist you in finding a new location with a new challenge. Physicians in all specialties are urgently needed throughout the country. Many types of situations available. Confidentiality assured.

Contact Donna Herschleb, RN
MEDICAL PROFESSIONAL PLACEMENTS
5222 Painted Post Drive, Madison, Wisconsin 53716
Phone: (608) 222-2927 *Licensed Employment Agency*

General and vascular surgeon, FACS, Board certified, highly qualified, with several years of practice, would like to join an individual or group with an established practice in metropolitan Milwaukee area. Contact Dept 493 in care of the Journal. 3tfn/82

Physician wanted to perform light physicals on a full or part-time basis. Ideal job for retiring physician. Contact Mike Stough collect at 513/621-8728. 10 tfn/81

The Racine Medical Clinic, a progressive cluster corporation of 25 physicians, is currently seeking an orthopedic surgeon and an invasive cardiologist. Full benefits, unlimited earnings and a full and exciting practice are offered. Please contact: Roger D Lacock, Administrator, Racine Medical Clinic, 5625 Washington Ave, Racine, WI 53406; ph 414/886-5000. 1tfn/82

Family physician, Board Certified or Eligible, to join four-man family practice group in northwest Wisconsin. First-year guaranteed salary. New clinic building located adjacent to 46-bed hospital, in the heart of Wisconsin's vacationland. Call shared with other family practice physicians in area, weekend coverage contracted. Jeanne Chamberlain, Adm, Spooner Clinic Ltd, 707 Ash St, Spooner, Wis 54801. Ph 715/635-2151. 12/81; 1-5/82

Pediatric, Family Practice positions available in 13-member multispecialty group. Inquire: General Clinic of West Bend, Inc, 279 S 17th Ave, West Bend, Wis 53095. 2tfn/82

Locum tenens services. Wisconsin-licensed family physician available and also needed. Our Physicians do Office, Hospital, Emergency Room and OB work. Call or write: INTER-HEALTH, Attn: J Slazek, 5695 Merry Lane, Excelsior, MN 55331; ph 612/474-4372. 4-6/82

Multispecialty group (13) Door County Wisconsin needs to replace retiring OB-GYN and General Surgeon. Write Door County Medical Center, PO Box 447, Sturgeon Bay, Wis 54235 or call John D Turk, Admin, at 414/743-7261. 2-4/82

Student Health Physician for campus of 10,000 students. Rare evening or weekend responsibilities. Salary negotiable. Good benefits. A nine-month position starting August 23, 1982. Send Curriculum Vitae to Charles Bass, MD, Director, Student Health Service, University of Wisconsin-Eau Claire, Eau Claire, Wis 54701. Affirmative Action Employer. Closing date June 1, 1982. 4-5/82

Emergency Physician, Appleton/Oshkosh: 8-man fee-for-service group is expanding. ER residency trained or ABEM certified physician preferred. Excellent staff backup, paramedics, telemetry. Above average salary. Numerous fringe benefits including corporation-paid retirement, malpractice, etc. Send CV to Thomas Loescher, MD, 2520 Crestview Drive, Appleton, WI 54911; ph 414/734-6351. 4-5/82

Busy OB/GYN Practice—associated required. Board certified or eligible. Guaranteed salary for first year with fringe benefits. Mohammad Shafi, MD, 606 W Wisconsin Ave, Milwaukee, Wis 53202; ph 414/276-7632. 4-6/82

Medical Facilities

Clinic pharmacy wanted in Milwaukee or Ozaukee counties by an expanding group practice of pharmacists. Capital available. Contact Dept 500 in care of the Journal. 4-6/82

Medical office space for lease. New Swiss chalet style building in fast growing community. Needs family practitioner, pediatrician, etc. Building has dentist and pharmacy. Very reasonably priced in Waukesha County near expressway. Info: call 414/781-1155. 3tfn/82

For Sale. Narco Bio-systems Arterial Diagnostic Unit, with bi-directional doppler. Automatic cuff inflator, and cardiac monitoring. Excellent condition. Send response to Burlington Clinic, SC, 325 East Jefferson St, Burlington, Wis 53105. p4-5/82

Milwaukee. Busy family medical center for sale. Will introduce. Good for teaching interns and residents in Family Practice. Contact: R Gonzalez, MD; ph 414/344-1120 or 414/476-8624. 3-8/82

Office Space For Rent. Three examining rooms, one x-ray room, and waiting room in medical clinic in a town of 3000. This clinic formerly provided a very strong practice for two family practitioners for 15 years. The village of Sturtevant is located three miles from a new major medical center. Just south of Milwaukee and near Lake Michigan where fishing and sailing is just minutes away. Also, inland lake living is within seven miles of here. One or two physicians interested in a long term commitment will find the lease terms to be *very* reasonable and land is available to add on to or to remodel the present clinic area. Contact Ronald E Schroeder, 8700 Racine Ave, Sturtevant, Wis 53177; ph 414/886-4178. 2-4/82

Immediate solo practice available in Jefferson, Wisconsin, due to the recent death of Richard H Siedenburg, MD. Expandable building with three large lots available. Lease or purchase. Contact Miller Law Office, PO Box 417, Jefferson, Wisconsin 53549; ph 414/674-3345. g11tfn/81

Prime east Madison medical office space to share. 2000 sq ft. Fully equipped and well furnished. Private office and sound proof examining rooms. X-ray, lab, and physical therapy facility on premises. Equipped minor surgery room. Share rent and staff expenses on a 50-50 basis or prorated to your needs. For more information and appointment to view facility, call C A Gencheff, DO: 608/241-3451. 12/81-1/82*

For Sale. diagnostic equipment including Standard x-ray, Clay Adams blood chemistry analyzer, Accustat blood cell counter, centrifuge, Lumiscribe portable minigraph EKG, examining tables and cabinets, office furniture and equipment and other miscellaneous. Contact Dept 499 in care of the Journal or call 414/965-2600 after 8:00 AM. 3-5/82

Miscellaneous

Physicians Signature Loans to $50,000. Up to 7 years to repay. No prepayment penalties. Prompt, courteous service. Physicians Service Assn, Atlanta, GA. Toll-Free (800) 241/6905. 4tfn/82*

Shopping for an Airplane? Lowest prices in US on new and used aircraft. All types available, prompt delivery. We are wholesalers—Call us Toll-Free (800) 241/6905. Physicians Service Assn, Atlanta, GA. 4tfn/82*

Real Estate

A SAFE TAX SHELTER. Land ownership offers more. The new A.C.R.S. (Accelerated Cost Recovery System). Depreciation + Inflationary Appreciation + Investment Credits, all put money into your pocket. FAITH REALTY—Est 1960, Farm Specialist-Tax Consultant, Whitewater, Wis 53190 (414/473-2779). PS: Who do you know who wants to buy a farm? p3-8/82

CONSULTANT FOR FLORIDA REAL ESTATE

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THE BEAUMONT 500

The Aesculapian Society of the SMS Charitable, Educational and Scientific Foundation has established a Medical Museum Endowment Fund to fund the operation and maintenance of the Fort Crawford Medical Museum at Prairie du Chien. The goal is to establish a permanent fund of at least $500,000, the corpus of which will not be utilized for any purpose except the production of income which, in turn, will be earmarked for museum operations.

Physicians who make a "once in a lifetime" contribution of $1,000 or more to the endowment fund will become members of a select group of physicians known as the "Beaumont 500." In addition to belonging to this prestigious group, physicians who contribute $10,000 or more will receive a first edition copy of Dr William Beaumont's famous book: *Experiments and Observations on the Gastric Juice and Physiology of Digestion,* first published in 1833.

For more than 20 years, the Fort Crawford Medical Museum has helped familiarize citizens with the fascinating people and events that have helped shape Wisconsin medicine. Your gift to the Medical Museum Endowment Fund will help preserve Wisconsin medical history for future generations. Please consider making your gift today. ■

Meetings/CME Courses

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates: 40¢ per word, with a minimum charge of $16.00 per listing. BOXED LISTINGS: $32.00 per column inch. COPY DEADLINE for Continuing Medical Education listings is tenth of the month preceding the month of publication; e.g., copy for the August issue is due by July 10. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 800/362-9080. For listing of other meetings see the Special issue of the Journal of the American Medical Association: Continuing Education Courses for Physicians for period Sept 1, 1981 through Aug 31, 1982.

WISCONSIN

MAY 5-7, 1982: *Fifth Annual Cardiac Rehabilitation Symposium,* Red Carpet Inn, Milwaukee. Sponsored by Mt Sinai Medical Center, Milwaukee; University of Wisconsin-Extension, Dept of Continuing Medical Education; American Heart Association, and American College of Sports Medicine. Approved 25 credit hours of Category 1 AMA; AOA Category 2-D, University of Wisconsin Continuing Education Units. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

MAY 6-7, 1982: *Trends in Radiologic Technology—1982,* Wisconsin Center, Madison. Sponsored by Allied Health Program Unit, UW-Extension; Dept of Radiology, School of Medicine, University of Wisconsin. ECE points applied for from ASRT, University of Wisconsin Continuing Education Units. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, WI 53706; ph 608/263-2856.

MAY 13-14, 1982: *8th National Conference on Case Resolution of Complex Industrially Injured,* Pioneer Inn, Oshkosh. Sponsored by Industrial Injury Clinic, University of Wisconsin-Extension, Continuing Medical Education, in cooperation with Theda Clark Regional Medical Center. AMA Category I, Continuing Legal Education credits, Commission on Rehabilitation Counselor Certification, University of Wisconsin Continuing Education units. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, WI 53706; ph 608/263-2856.

MAY 14-16, 1982: *Annual Meeting of the American Association of Medical Assistants, Inc, Wisconsin Society,* Mead Inn, Wisconsin Rapids. See details elsewhere in this issue.

MAY 23-25, 1982: Wisconsin Chapter, American Academy of Pediatrics, Playboy Club, Lake Geneva.

MAY 23-25, 1982: Wellness Seminar, Devils Head Lodge, Merrimac. Sponsored by Sauk Prairie Memorial Hospital, and John A McAuliffe, MD, director of "Project Life." Fee: $200. This two and one-half day seminar will include all of the latest techniques and materials needed to plan, implement, and manage a cost effective "Turn Key" wellness program. Info: Claudia Bannon, Project Life Coordinator, Sauk Prairie Memorial Hospital, Prairie du Sac, Wis 53578; ph 608/643-3311.

JUNE 4-5, 1982: *Diabetes Mellitus—1982,* Madison. Sponsored by University of Wisconsin School of Medicine, Department of Medicine; and University of Wisconsin-Extension, Continuing Medical Education. AMA Category I, AOA Category 2-D, AAFP, University of Wisconsin Extension Continuing Education Units. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

JUNE 6-10, 1982: *Managing Health Care Resources in the Competitive Environment of the 1980s,* La Crosse. Sponsored by Western Wisconsin Health Systems Agency, University of Wisconsin Extension, and the University of Wisconsin La Crosse Business Outreach Department. Guest speakers include, Dr Alain Enthoven, Stanford University; Dr Erik Ritman, Mayo Medical School; and Dr Larry Cummings, Northwestern Univer-

STATE MEDICAL SOCIETY OF WISCONSIN
Dates and Locations of Annual Meetings
1982-1992

All meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) and the new Hyatt Regency as the headquarters hotel with the exception of 1985, when the meeting will be held at the LaCrosse Convention Center.

1982—May 13-15	**1987—Mar 26-28**
1983—Mar 24-26	**1988—Apr 28-30**
1984—Mar 29-31	**1989—Apr 13-15**
1985—Apr 25-27	**1990—Apr 26-28**
1986—Apr 17-19	**1991—Apr 18-20**
	1992—Apr 23-25

Meeting days will be Thursday and Friday; the first session of the House of Delegates will convene on Thursday, the second and third on Friday. Scientific programming will be on Friday and Saturday.

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701. Local telephone: 257-6781; toll-free in Wisconsin: 1-800/362-9080.

DYING WITH ONE'S RIGHTS ON?:
THE MENTAL HEALTH COMMITMENT LAWS

Thursday, June 10, 1982
Pfister Hotel, Milwaukee

A forum presented by the Department of Psychiatry, Mount Sinai Medical Center; and co-sponsored by: The Milwaukee Bar Association, Milwaukee Psychiatric Hospital, and The Wisconsin Psychiatric Association

The Presenters: *Jules Coleman, PhD,* Tucson, Ariz; *David Saicheck,* Milwaukee; *Alan A Stone, MD,* Cambridge, Mass; *Thomas Szasz, MD,* Syracuse, NY; *Darold A Treffert, MD,* Fond du Lac; *Mona Wassow, MSW,* Madison; and *Thomas Zander,* Milwaukee

Registration: $55. Info: Ms Sue Reichard, Mount Sinai Medical Center, 950 N 12th St, PO Box 342, Milwaukee, Wis 53201; ph 414/289-8026.

sity. Info: Thomas M Lynch, Conference Director, Western Wisconsin Health Systems Agency, 1707 Main, La Crosse, WI 54601; ph 608/785-9352.

JUNE 16-AUGUST 4, 1982: *University Forum on Health,* eight weekly lectures on Wednesday evenings from 7-9 pm in Room 3650, Humanities Building, University of Wisconsin-Madison. See details elsewhere in this section.

JUNE 7-11, 1982: *Cardiac Rehabilitation Workshop,* La Crosse. See details elsewhere in this section.

JUNE 10, 1982: *Dying With One's Rights On? The Mental Health Commitment Laws,* Pfister Hotel, Milwaukee. Sponsored by Department of Psychiatry, Mount Sinai Medical Center and co-sponsored by The Milwaukee Bar Association, Milwaukee Psychiatric Hospital, and the Wisconsin Psychiatric Association. Info: Susan R Reichard, Mount Sinai Medical Center, 950 N 12th St, PO Box 342, Milwaukee, Wis 53201; ph 414/289-8026. (Further details elsewhere in this section.)

JUNE 10-11, 1982: *New Therapeutics in Cardiology and Infectious Diseases,* Madison. Sponsored by University of Wisconsin-Extension, Dept of Continuing Medical Education; and University of Wisconsin, School of Medicine, Dept of Medicine. AMA Category 1, AOA Category 2-D; AAFP, University of Wisconsin-Extension Continuing Education Units. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

JUNE 14-18, 1982: *Cardiac Rehabilitation Workshop,* La Crosse. See details elsewhere in this section.

JUNE 14-18, 1982: *15th Annual Postgraduate Course in Gynecological Pathology, Endocrinology, and Maternal-Fetal Medicine,* Medical College of Wisconsin, Alumni Center, Milwaukee. Guest faculty includes H W Jones Jr, MD; Georgeanna S Jones, MD; J D Woodruff, MD, and Robert C Young, MD. $500 enrollment fee will include 68 selected 35mm slides. Registration limited to 150. Approved 41 credit hours of Category 1 of AMA-PRA and AAFP. Also approved for 41 Cognates, Formal Learning, by the American College of Obstetricians and Gynecologists. Info: Richard F Mattingly, MD, Professor and Chairman of Gynecology and Obstetrics, Medical College of Wisconsin, 8700 West Wisconsin Ave, Milwaukee, Wis 53226.

JUNE 16, 1982: *What's New in Alzheimer's Disease,* Mount Sinai Medical Center, Milwaukee. Info: Susan R Reichard, Mount Sinai Medical Center, 950 N 12th St, PO Box 342, Milwaukee, Wis 53201; ph 414/289-8200. (Further details elsewhere in this section.) g4-5/82

Cardiac Rehabilitation Workshops

Offered through the joint effort of the La Crosse Exercise Program and La Crosse Lutheran Hospital/Gundersen Clinic, Ltd, six times throughout the year as follows:

March 1-5	**June 7-11**	**July 12-16**
April 19-23	**June 14-18**	**Sept 20-24**

Workshops provide an indepth understanding and experience of all aspects of cardiac rehabilitation and a thorough understanding of the organizational and administrative aspects of a cardiac rehabilitation program. Workshops will consist of didactic lecture with structured laboratory experiences and examinations. Accreditation through a number of agencies is offered. For further information contact:

Dr Philip K Wilson, Workshop Unit-La Crosse Exercise Program, Mitchell Hall/University of Wisconsin-La Crosse, La Crosse, Wis 54601; phone 608/785-8686

JUNE 16-19, 1982: Annual Scientific Assembly of the Wisconsin Academy of Family Physicians, Radisson Hotel, La Crosse. Approved 20 credit hours Category 1 of AMA-PRA. Info: Robert H Herzog, Wisconsin Academy of Family Physicians, 850 Elm Grove Rd, Elm Grove, Wis 53122; ph 414/784-3656.

JUNE 17-23, 1982: *Fifteenth Annual Postgraduate Course in Gynecological Pathology, Cytogenetics and Endocrinology,* Pfister Hotel and Tower, Milwaukee. Sponsored by The Medical College of Wisconsin, Milwaukee. Fee: $500 enrollment fee will include 68 selected 35mm slides. Approved 42 credit hours of Category I of AMA-PRA and AAFP. Info: Richard F Mattingly, MD, Medical College of Wisconsin, 8700 West Wisconsin Ave, Milwaukee, Wis 53226.

JUNE 18-19, 1982: *Advances in Developmental Abnormalities: Clinical, Genetic, Radiological, and Pathologic Aspects* Madison. Sponsored by University of Wisconsin School of Medicine and University of Wisconsin-Extension, Continuing Medical Education. Approved 11 credit hours Category I of AMA and Extension Continuing Education Hours. Fee: $140. Info: Sarah Z Aslakson, Continuing Medical Education, 465B

1982 UNIVERSITY FORUM ON HEALTH

Presented by the University of Wisconsin-Madison Medical School and the Schools of Allied Health Professions, Nursing, and Pharmacy, all components of the Center for Health Sciences.

Weekly lecture/discussions on Wednesday evenings from 7-9 pm in Room 3650, Humanities Building.

Wednesday evenings—June 16 to August 4

Eight outstanding speakers will focus on health from the perspective of personal, professional, and social responsibilities:

- June 16—Philip Lee, MD, University of California, *The Nation's Health: Individual and Social Responsibility*
- June 23—William Nolen, MD, Litchfield, Minnesota, *Surgery and Healing*
- June 30—Don E Detmer, MD, UW-Madison Professor of Preventive Medicine and Surgery, *Physician-patient Relationships*
- July 7—Charlotte Anderson-Smith, RPh, MS, UW-Extension, *Treat Yourself Right: Rational Self-medication*
- July 14—Nancy Watts, PhD, Education Provost, Massachusetts General Hospital, *Taking Control of Your Own Health?*
- July 21—Alfred E Harper, PhD, UW-Madison Professor of Biochemistry and Nutritional Sciences, *Diet, Nutrition and Health*
- July 28—Jerry J Noren, MD, UW-Madison Assistant Professor of Preventive Medicine, *Health and Environment*
- August 4—Catherine Murphy, RN, EdD, Boston, College, *Ethical Decisions in Health.*

Moderator: Joseph M Benforado, MD, Professor of Medicine, Center for Health Sciences.

All interested persons may attend free of charge, or may register for the Forum as a one-credit Summer Sessions course.

Further information: Howard L Stone, PhD, Director, Office of Educational Resources, School of Medicine, Medical Sciences Center, 1300 University Ave, Madison, Wis 53706 (phone: 608/263-4714).

WISCONSIN continued

WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

JUNE 24-25, 1982: *Obstetrical Events and Neonatal Brain Injury,* Wisconsin Center, Madison. Sponsored by Continuing Medical Education, Health Sciences Unit, University of Wisconsin-Extension and Departments of Family medicine and Practice, Pediatrics, Gynecology and Obstetrics, School of Medicine, University of Wisconsin, Madison, and Madison General Hospital and St Marys Hospital Medical Center. Twelve credit hours, AMA; AOA; CEU's ACOG applied for. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

JULY 12-16, 1982: *Cardiac Rehabilitation Workshop,* La Crosse. See details elsewhere in this section.

JULY 16-17, 1982: Wisconsin Society of Obstetrics and Gynecology, Leathem Smith Lodge, Sturgeon Bay.

JULY 30-AUG 1, 1982: *EKG Interpretation and Arrhythmia Management,* Abbey Resort, Lake Geneva. Fee: $245 physicians; $130/Nurses & Technicians. Approved 13 credit hours Category 1 of AMA-PRA and prescribed AAFP; ACEP. Info: International Medical Education Corporation, 64 Inverness Drive East, Englewood, CO 80112; ph 800/525-8651 or 303/740-8445, ext 123. 4-6/82

AUGUST 6-8, 1982: Wisconsin Dermatological Society summer meeting, Lake Geneva, Wis. Info: Robert A McDonald, MD, 1313 Fish Hatchery Rd, Madison, Wis 53715.

GERIATRIC CONFERENCE
WHAT'S NEW IN ALZHEIMER'S DISEASE

Wednesday, June 16, 1982
Mount Sinai Medical Center
Milwaukee, Wisconsin

- The Background of Alzheimer's Disease, *Albert A Fisk, MD,* Medical Director, Wisconsin Regional Geriatric Center
- Neurotransmitters and The Etiology of Alzheimer's Disease, *Gregory L Schmidt, MD,* Assistant Professor of Psychiatry, UW Medical School, Milwaukee
- The Diagnosis of Alzheimer's Disease, *David S Dahl, MD,* Professor of Neurology, Milwaukee Clinical Campus, UW Medical School
- Neuropsychological Testing of Alzheimer's Disease, *Kerry Hamsher, PhD,* Director, Neuropsychology at Mount Sinai Medical Center
- Day Care for Alzheimer's Disease Patients: Alzheimer's Disease Day Hospital Program of Wisconsin Regional Geriatric Center, *Albert A Fisk, MD;* The Research Component, *Iris R Winogrond, PhD;* The Patient Program, *Barbara Keyes, RN;* The Family Education and Support Group, *Gregory Szpak, MSW*
- The Family and Alzheimer's Disease Patients, *Bella H Selan, MS,* Director of Late Life Services, Mount Sinai Medical Center
- Mentally Impaired Elderly in the Community, *Eugene M Dagon, MD,* Director of Geropsychiatry, Milwaukee County Mental Health Complex

Fees: $40, Physicians; $20, Nurses and Allied Professionals

Info: Public Relations Department at Mount Sinai Medical Center, 414/289-8026. g4-5/82

SEPTEMBER 9-11, 1982: Wisconsin Society of Internal Medicine and American College of Physicians joint meeting, Holiday Inn Downtown, Green Bay. Info: Kim Marggraf, Wisconsin Society of Internal Medicine, 611 East Wells St, Milwaukee, Wis 53202.

SEPTEMBER 20-24, 1982: *Cardiac Rehabilitation Workshop,* La Crosse. See details elsewhere in this section.

OCTOBER 16, 1982: Wisconsin Radiological Society, Concourse Hotel, Madison.

NOVEMBER 5, 1982: Wisconsin Orthopaedic Society, Olympia Resort, Oconomowoc.

OTHERS

MAY 12-14, 1982 (Illinois): *Twenty-Sixth Annual Post-graduate Course on Fractures and Other Trauma,* John B Murphy Auditorium, American College of Surgeons, 55 E Erie, Chicago, Ill. Sponsored by the Chicago Committee on Trauma of the American College of Surgeons. Speaker: Charles C Edwards,

WISCONSIN: SPECIALTY SOCIETY MEETINGS: 1982

Wisconsin Urological Society, Apr 30-May 1, 1982, Concourse Hotel, Madison

Wisconsin Chapter: American Academy of Pediatrics, May 23-25, 1982, Playboy Club, Lake Geneva

Wisconsin Academy of Family Physicians, June 17-20, 1982, Radisson Hotel, La Crosse

Wisconsin Society of Obstetrics & Gynecology, July 23-24, 1982, Leathem Smith Lodge, Sturgeon Bay

Wisconsin Neurological Society, Fall (September ?) 1982

Wisconsin Surgical Society, Sept 9-10, 1982 Holiday Inn and/or Radisson Hotel, La Crosse

Wisconsin Society of Internal Medicine, Sept 9-11, 1982, Holiday Inn (Downtown), Green Bay

Wisconsin Society of Anesthesiologists, Sept 9-12, 1982, Concourse Hotel, Madison

Wisconsin Radiological Society, Oct 16, 1982 Concourse Hotel, Madison

Wisconsin Allergy Society, Oct 9-10, 1982, Pioneer Inn, Oshkosh

Wisconsin Chapter: American College of Emergency Medicine, October 1982, The Pfister Hotel & Tower, Milwaukee

Wisconsin Orthopaedic Society, Nov 5, 1982, Olympia Resort, Oconomowoc

SPECIALTY SOCIETY MEETINGS TO BE HELD IN CONJUNCTION WITH SMS ANNUAL MEETING, May 13-15, 1982, Milwaukee

Wisconsin Allergy Society
Wisconsin Orthopaedic Society
Wisconsin Society of Internal Medicine
Wisconsin Society of Pathologists
Wisconsin Society of Physical Medicine and Rehabilitation
Wisconsin Society of Plastic Surgeons
Wisconsin Society for Preventive Medicine
Wisconsin Society of Radiation Oncologists
Wisconsin Surgical Society

MD, Chief of Orthopaedics, University of Maryland, Baltimore. The program will honor Dr William A Hark, who devoted years of service to education in the Chicago area and was a participant of the Chicago Committee on Trauma. Info: Jack L Robbins, MD, Chairman, 2500 Ridge Ave, Evanston, IL 60201; ph 312/475-4040. p4/82

MAY 19-22, 1982 (Florida): *Twenty-second International Conference on Legal Medicine,* sponsored by American College of Legal Medicine, at Boca Raton Hotel and Club, Boca Raton. Info: American College of Legal Medicine, 875 North Michigan Ave, Suite 3744, Chicago IL 60611.

MAY 21-22, 1982 (Iowa): *Midwest Conference on Health Care in the Elderly,* Fifth Annual Meeting, Iowa City. Sponsored by The University of Iowa College of Medicine, Departments of Internal Medicine and Family Practice, and the Iowa Gerontology Project. Two-day meeting of varied presentations of many aspects of geriatric medicine. AMA Category I credit, 15.5 hours. For additional information: Ian M Smith, MD, Dept of Internal Medicine, University of Iowa Hospitals, Iowa City, Iowa 52242; ph 319/356-2727. g3-4/82

JUNE 2-4, 1982 (Illinois): *Problem Solving in Lung Disease: A Practical Approach,* Chicago. Info: Registrar, American College of Physicians, 4200 Pine St, Philadelphia, PA 19104.

JUNE 14-16, 1982 (Canada): *Critical Care Medicine-1982,* Banff, Alberta. Info: Registrar, American College of Physicians, 4200 Pine St, Philadelphia, PA 19104.

JUNE 24-26, 1982 (Washington DC): *The Primary Care Physician and Cancer,* Hyatt Regency Washington on Capitol Hill. American Cancer Society National Conference is being held in cooperation with the American Academy of Family Physicians. No registration fee, advance registration is requested. Approved 17.5 credit hours of Category I of AMA-PRA and AAFP. Program is eligible for 17.5 credit hours in Category 2-D of the American Osteopathic Association. Info: Nicholas G Bottiglieri, MD, American Cancer Society National Conference, The Primary Care Physician and Cancer, 777 Third Ave, New York, NY 10017. g4/82

JUNE 26-JULY 10, 1982 (Austria/Monaco): *XIIth World Congress on Sports Medicine* in Vienna, Austria June 26-July 4 and *Post Congress Symposium* in Monte Carlo, Monaco, July 4-10. "Practical Application of Sports Medicine for Physicians, Trainers, and Coaches." Contact PO Box 66, Shawnee Mission, Kansas 66201 or call 800-255-6969. 2-5/82*

JUNE 28-30, 1982 (Korea): 6th Joint Scientific Meeting of The Korean Medical Association of America and The Korean Medical Association, Lotte Hotel, Seoul. Info: The Korean Medical Association of America, 800 MacArthur Blvd, #24, Munster, Ind 46321; ph 218/836-2151. g4/82

JULY 29-AUGUST 1, 1982 (Illinois): *International Doctors in Alcoholics Anonymous, Annual Meeting.* Hotel reservations directly at Ramada the O'Hare Inn, 6600 N Mannheim Rd, Des Plaines, Ill 60018 or call 312/827-5131 or 800/288-2828. (Be sure to specify IDAA for special rates). Further information contact Secretary IDAA, 1950 Volney Rd, Youngstown, Ohio 44511; ph 216/782-6216. g2tfn/82

AMA

JUNE 13-17, 1982: Annual AMA House of Delegates, Downtown Chicago Marriott, Chicago, Ill.

JUNE 19-23, 1983: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 4-7, 1983: Interim AMA House of Delegates, Los Angeles, CA.

DECEMBER 5-8, 1982: Interim AMA House of Delegates, Miami Beach, Fl. ■

IMEC

1982 POSTGRADUATE SEMINARS

- Nationally-Renowned Faculty
- Weekend Seminars
- Credit: A.M.A. Cat. I, A.A.F.P. Prescribed, A.C.E.P. Cat. I*, A.C.S.M.**, A.N.A.

Arrhythmias & Cardiac Ischemia: Diagnosis & Management*

June 11-13 Las Vegas, NV
June 11-13 Virginia Beach, VA
July 16-17 San Francisco, CA
July 16-18 Vail, CO
July 30-Aug. 1 Boyne Mountain Resort Boyne, MI
August 13-15 Orlando, FL
September 24-25 Washington, DC
October 22-23 Cincinnati, OH
October 29-31 Las Vegas, NV

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June 25-27 Newport Bch., CA
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July 30-Aug. 1 Lodge of the Four Seasons Lake of the Ozarks, MO
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July 30-Aug. 1 Lake Geneva, WI
August 6-8 Lake Tahoe, NV
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September 24-26 Las Vegas, NV
October 15-16 Atlanta, GA
October 22-23 Chicago, IL

Cardiac Rehabilitation**

May 14-15 St. Louis, MO
September 24-25 Philadelphia, PA
October 15-16 Detroit, MI
October 29-30 Chicago, IL

Ambulatory Electrocardiography: Clinical Applications, Methodology & Interpretation

May 7-9 Las Vegas, NV
June 25-26 Toronto, Canada
July 16-18 Orlando, FL
August 6-8 Concord Resort Kiamesha Lk., NY (The Catskills)
August 20-22 Anaheim, CA
September 24-25 Houston, TX
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News You Can Use

By EARL THAYER, Secretary / BERNIE MARONEY, Assistant Secretary

FTC HAS JURISDICTION OVER AMA, SUPREME COURT RULES. On a tie vote March 23 the US Supreme Court upheld a lower court ruling that the FTC has the authority to regulate competitive practices of professional organizations. The tie vote will not set a precedent for the issue and the court may agree to study the issue again. Representatives from AMA as well as other professional groups now may look to Congress where legislation is pending that would limit the FTC's reach.

The AMA has argued that FTC jurisdiction covers only corporations engaged in business activities for profit and that the FTC should have taken into account 1977 revisions in doctor advertising standards.

Earlier in March, the Broward County (Fla) Medical Association signed a consent decree with the Federal Trade Commission agreeing not to suppress "truthful advertising" about fees and services by its 1,500 members. The association signed the consent decree in order to avoid incurring legal fees in fighting a December 1981 FTC decision that stated the BCMA was "engaged in a conspiracy . . . to prohibit, restrict, and otherwise interfere with advertising" in classified section of telephone directories." It also alleges that BCMA was interfering with physicians' efforts to compete "by advertising in newspapers and soliciting patients' business." The decree does not prohibit BCMA "from formulating, adopting, disseminating to its members, and enforcing reasonable ethical guidelines governing the conduct of its members with respect to representation, including unsubstantiated representation" that it reasonably believes to be false and deceptive.

AMA PROFESSIONAL PUBLICATIONS LISTING AVAILABLE. The American Medical Association has released a new updated catalog of current AMA publications for physicians. The catalog, available at no charge from the AMA Ordering Dept, 535 N Dearborn St, Chicago, IL 60610, gives order instructions, forms and price information. Physicians will find the professional publications helpful in improving their practices and in expanding their awareness of socio-economic factors which affect medical practice.

STATE DOCTORS ASKED TO PARTICIPATE IN STUDY. More than 4,000 Wisconsin physicians will be asked to take part in a study to see if aspirin lowers the risk of heart attack and stroke and if beta carotene reduces the risk of lung cancer, the *Journal of the American Medical Association* has reported. The study is funded by $3,732,831 from the National Heart, Lung and Blood Institute and National Cancer Institute and will be conducted by the Harvard Medical School. The physicians eventually selected for the study—males between 40 and 75—will take the aspirin, beta carotene, or placebos for at least five years.

NEW LAW CHANGES DOCTOR'S ROLE IN ADOPTIONS. Under a new law which became effective February 1, 1982, physicians and others may act as intermediaries in finding children for adoption or making placements. Previously only licensed child welfare agencies or a public agency authorized to place children for adoption could place a child in a home for adoption without court approval. Assembly Bill 369 creates a procedure for consensual or private adoptions in Wisconsin. Under that procedure, the birth parent and the proposed adoptive parents must file a verified petition for adoption placement which identifies the birth parents, child, proposed adoptive parents, and any person or agency assisting in the placement of the child with the proposed adoptive parents. ***The petition must also describe each transfer or anything of value from the proposed adoptive parents to the birth parents or another on behalf of the birth parents.*** The new law establishes stiff penalties against the birth parent who accepts anything of value beyond hospital and medical expenses of the birth mother and legal and other expenses in connection with the adoption. ***Anyone who solicits, negotiates or arranges the placement of a child for adoption in violation of the established procedures and in return for anything of value, is also subject to penalty.*** A detailed article on this subject will appear in the 1982 "Blue Book" issue of the *Wisconsin Medical Journal.* ■

Bactrim™
(trimethoprim and sulfamethoxazole)
succeeds

Bactrim is useful for the following infections when due to susceptible strains of indicated organisms (see indications section in summary of product information):

Expanding its usefulness in antimicrobial therapy

in recurrent UTI...
a continuing record of high clinical effectiveness against common uropathogens

in acute otitis media in children...
effective against both major otic pathogens...with *b.i.d.* convenience

in acute exacerbations of chronic bronchitis in adults...
clears the sputum and lowers its volume...on *b.i.d.* dosage

in shigellosis...
faster relief of diarrhea than with ampicillin[2]

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. Limited clinical information presently available on effectiveness of treatment of otitis media with Bactrim when infection is due to ampicillin-resistant *Haemophilus influenzae*. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.

For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.

For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.

Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: *General:* Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:

Adults. Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.

Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.

For patients with renal impairment. Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.

ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:

Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days.

PNEUMOCYSTIS CARINII PNEUMONITIS:

Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100; Prescription Paks of 20 and 28. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40. *Pediatric Suspension,* containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); cherry-flavored—bottles of 100 ml and 16 oz (1 pint). *Suspension,* containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).

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1. Rubin RH, Swartz MN: *N Engl J Med* 303:426-432, Aug 21, 1980. **2.** Data on file, Medical Department, Hoffmann-La Roche Inc.

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WISCONSIN MEDICAL JOURNAL

MAY 1982

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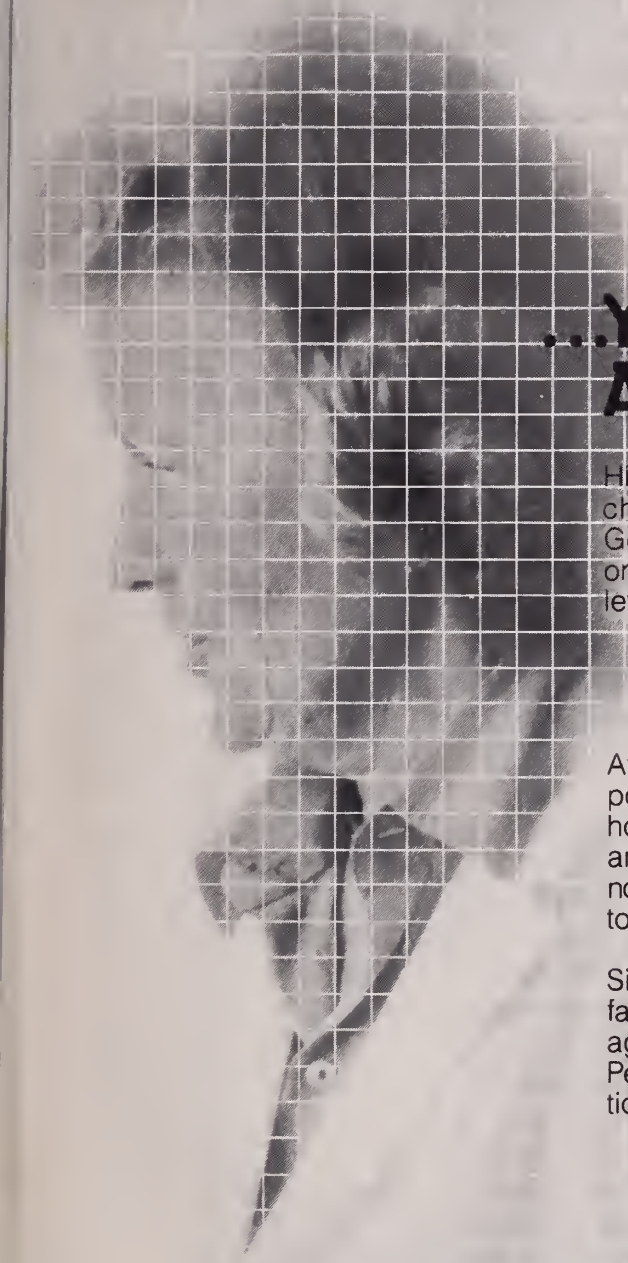
THE PATIENT THINKS HE HAS HEART TROUBLE...



...YOU KNOW IT'S REALLY ANXIETY SYMPTOMS

His presenting symptoms: palpitations, chest pain, chronic exhaustion and occasional difficulties in breathing. Good reason for concern. A complete workup uncovers no organic dysfunction, but it *does* reveal excessively high levels of anxiety and apprehension.

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VALIUM® (IV)
diazepam/Roche

2-mg, 5-mg, 10-mg scored tablets

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The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.
Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients Caution against hazardous occupations requiring complete mental alertness When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures Advise against simultaneous ingestion of alcohol and other CNS depressants Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy
Dosage: Individualize for maximum beneficial effect. *Adults.* Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed, adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).
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President's Page

ALBERT J MOTZEL JR, MD

Physician-nurse interrelationships in the hospital setting

DURING THIS PAST YEAR an ad hoc committee of the State Medical Society met with most of the organizations representing individuals purveying some aspect of care to patients. These include dietitians, therapists, technicians, and the like. Foremost among the recommendations of this committee—a recommendation implemented by your Board of Directors—was that of the formation of a joint committee of physicians and nurses (by far the largest and most important to patient care of the many groups with whom the committee met).

Unlike the Joint Practice Committee which is dealing with a specific, albeit an important, problem facing a small number of both physicians and nurses—this is a group directed at examining problems, solutions, and improvement in the interrelationships of the vast majority of physicians and nurses in the hospital setting.

This group has the potential to be valuable in the accumulation and dissemination of ideas and information concerning workable interchange between physicians and nurses in various hospital settings in Wisconsin and elsewhere. However, the initiation of the really meaningful communication that will achieve the greatest benefit for patients will take place between individual physicians and nurses on the hospital ward where you and I—and they—work. (I was tempted to say "spontaneously," but on further reflection it is likely that what seems spontaneous may be the outcome of the receptiveness and respect developed between a particular nurse and a particular physician.)

Ultimately it is the development of an atmosphere in which this mutual respect and receptiveness can take place in each individual institution that will further the ends of both professions in the delivery of better and more humane patient care. Granted there are a few sensitive—and sensitizing—individuals among both groups. The vast majority of both physicians and nurses would find a common ground in giving one another the information concerning the individual patient that would result in the most helpful and efficient care of the patient.

Physicians' overriding concern is their responsibility for the patient. However, this responsibility is best implemented when information concerning the patient's response to treatment during those periods when the physician is not immediately in attendance is made available through someone who is—the nurse. This creates a need for careful and intelligent observation on the part of the nurse which can certainly be best carried out with an understanding of the problems anticipated or the results expected during the period of observation. These tenets would seem fairly obvious, but lack of communication in this area is frequently the source of dissatisfaction and contention between physicians and nurses.

The nurse, on the other hand, may vary in background of education and experience, or in frequency of contact with the particular patient. If then the nurse's observations are to be meaningful and appropriate, there must be communication not only between physician and nurse but also among nurses themselves. The interrelationships among the members of the nursing team and entire nursing service must be one of cooperation and communication to improve the continuity of care as well as the knowledge and ability of each member of the team. Where this spirit of cooperation exists within the nursing staff the greatest opportunity for nurse-physician cooperation exists. Both the nurse and the physician share the responsibility of bringing this atmosphere into existence. This atmosphere is nurtured and advanced in the presence of a medical staff interested in helping nurses to increase their knowledge and ability—it is destroyed in the presence of unnecessary fault-finding and attribution of blame for insignificant incidents.

Let us hope that this ad hoc committee of nurses and physicians together can discover those institutions or services that have been most successful in this area of communication and help to transfer the prime ingredients of cooperation to all our hospitals to our mutual benefit. In the interim let us each promote such cooperation in our own institution. ■

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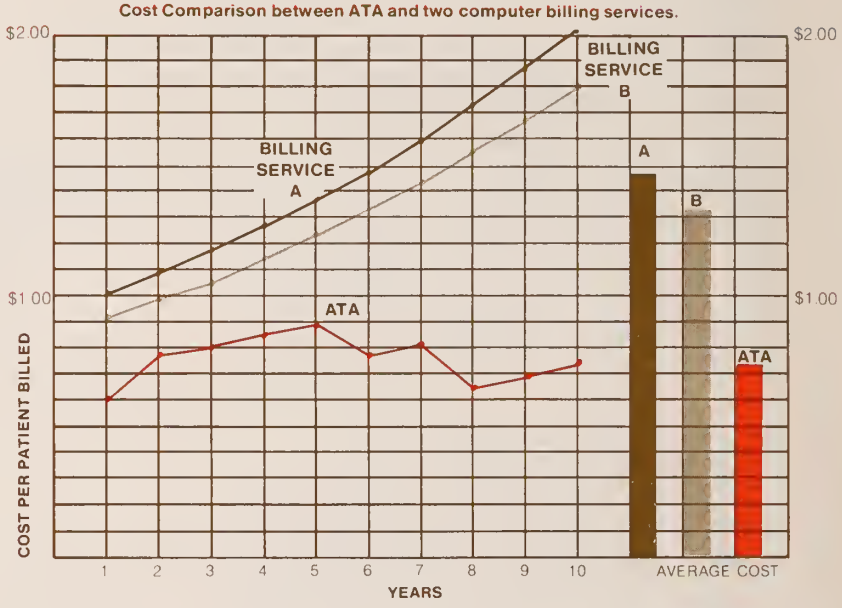

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Medical computer systems

Editorials WAYNE J BOULANGER, MD, *Editorial Director*

Official positions of the Society will be expressly identified as such; all others are views of the writer and not necessarily those of the Society.

Artificial insemination

SENATE BILL 783, passed by the Senate in March, provides that a physician who knowingly performs artificial insemination on a welfare recipient is guilty of unprofessional conduct. The Medical Society opposes this action on the grounds that unprofessional conduct laws are a means of protecting the public from illegal, incompetent, immoral or negligent behavior on the part of licensed professionals, and that properly performed artificial insemination really doesn't fit in any of these categories.

There must be a better solution than Senate Bill 783.

The Milwaukee County Medical Society Board of Directors, at the request of the Milwaukee County Executive, has agreed to take on the problem and prepare a position paper on the propriety of artificial insemination for unmarried welfare recipients. The matter was turned over to the Ethics Committee with instructions to look into the problem and report to the Board of Directors. The issue developed when a Milwaukee gynecologist provided the service for a single woman who is indigent. As might be expected, the taxpaying community was outraged, with much of the outcry directed at the physician, emphasizing economics rather than ethics.

As a matter of fact, the Milwaukee County Medical Society Ethics Committee has at this time not reached a consensus, and may well never do so. The Board of Directors could possibly have to complete its deliberations without their assistance.

Development of guidelines for artificial insemination shouldn't be that difficult. After all, the problem here doesn't pose the same sort of dilemma that abortion does. Antagonists in the abortion battle lack agreement on a key scientific point—determination of the moment when life actually begins—and until that can be settled, no one will get anywhere. But with artificial insemination all the necessary scientific information is widely known, and the only questions revolve around selection of the appropriate candidate.

Economics is not the major consideration here. The desire to have a child does not constitute the right to have one even if one can afford it. Nor does lack of ability to afford a child necessarily rule it out. To espouse any other point of view would be to adopt a double standard. The same rules should apply to all. In the United States families who wish to adopt a child must prove their ability to rear it properly before they are granted the opportunity. Why not apply those same criteria, developed over many years of trial and error, to artificial insemination? Apparently, this hasn't been done.

Strict guidelines administered by an appropriate agency would by their very nature tend to turn away the frivolous applicant who, with the red tape involved, would eventually lose enthusiasm. Guidelines would also take the onus off the physician who then would not have to be involved with evaluating the quality of those elements in family life which are important and necessary in raising children. He would merely function as the technician providing the service should he be qualified to do so.

One would be naive to believe that any sort of regulations will prevent an unworthy candidate from becoming pregnant should she chose to do so. But if appropriate guidelines for artificial insemination were available, the doctor would at least have a sensible course to follow. —WJB

Editor's Note: The Society urged and the Governor gave his veto to provisions in the Budget Repair Bill which incorporated the features of SB 783.

Backlog

THE CHICAGO TRIBUNE succinctly reported that 97 children have died in the last five years because a London hospital could not afford the bone marrow transplants that might have saved their lives. The 97 children suffered from gargoylism and all were on the hospital's waiting list.

Britain's tax-financed National Health Service is supposed to provide free health care for the nation's 56 million people. Because of the recession it has been necessary to cut back on service and facilities, leaving 632,000 people waiting for nonemergency treatment at hospitals, according to government estimates.

A similar situation was observed by a group of Wisconsin surgeons who toured Scandanavian medical centers several years ago. They learned that the waiting list of patients for cholecystectomies alone had a backlog of about 18 months. By the time these people got to surgery, their convalescence was often prolonged because of complications from the extended wait. Consequently, their hospital stays were longer, and the problem with the waiting list continued to compound itself.

The moral of the story is that National Health Services do not provide the level of care found in the free enterprise system. The result is extensive waiting lists of patients requiring care and the consequent unnecessary complications and deaths.

—VSF

Organoscopy

IN THIS ISSUE of the *Journal* there is a paper describing the use of laparoscopy in gastroenterology. Although the name has changed, and the role has varied, the technique of the procedure is essentially unchanged in 80 years.

The authors of the present paper list references going back to 1968. They point out the popularity of the procedure with gynecologists and more recently in the field of gastroenterology. The present paper stirred my memory back to 1941 when I was privileged to peer through the peritoneoscope over the shoulder of my surgical chief, JC Thomas Rogers, MD. Doctor Rogers wrote a paper in 1941 entitled "The Role of Peritoneoscopy in Abdominal Surgery."[1]

The historical background and references in Doctor Rogers' paper go back to 1901 when a German author reported on the visualization of the contents of the abdomen through an instrument on a living dog. The abdomen was inflated and a cystoscope introduced. By 1910 the same author reported on the examination of the intraabdominal contents by instrumental visualization in man. In 1911 the procedure, then called organoscopy, was carried out in Baltimore using a small proctoscope. Many of the early papers agree that the procedure was really valuable for the inspection of the liver and peritoneum. In 1934 the cystoscope was modified and became known as the peritoneoscope.

There are always new procedures and techniques in medicine. There are also some old, established procedures that are sometimes relegated to a status of less utilization. Whether it is called organoscopy, peritoneoscopy, or laparoscopy, the procedure has been with us for 80 years and is now utilized in several disciplines. —VSF

[1]Illinois Medical Journal 80 (3):222-228 (Sept) 1941.

Free clinics

DR ALBERT MOTZEL, President of our State Medical Society, recently proposed the reintroduction of the "free clinic." (*WMJ:* April 1982) This is an aspect of medicine that has been largely forgotten since the advent of Medicare, Medicaid, and other government-assisted programs.

Those of us old enough to have grown up through the depression years vividly recall the city and county hospitals and the attached clinics, and they were free. Local governments supported them in some meager manner. The leading physicians in a community devoted many hours to the hospital and clinics without recompense but received recognition. The interns and residents received only "room, board, uniforms, and laundry." Residents started at $25.00 a month and worked up to $50.00 with seniority. There was no moonlighting for the house staffs.

In Milwaukee the County Emergency Hospital on Wisconsin Avenue was the site of many clinics and medical students from both of the medical schools in the state worked there. Students from the University of Wisconsin would also go to the Chicago Maternity Center for two weeks experience with home deliveries. The usual mode of transportation for the home deliveries was either by streetcar or "L" or occasionally paying a prosperous intern the equivalent of carfare to ride in his car. This was all free for the patients, but the medical students paid their own way.

Well, enough of the nostalgia. The concept of free clinics is an old one and a good one. There are some unfortunates, probably now increasing, who are in a gray area. They are not eligible for any of the programs, which now seem to be shrinking, and can't afford the current cost of medical care. The level of medical care in this country is high and must not be allowed to deteriorate because of a recession. Physicians should make themselves available and provide care without recompense, if free clinics are reactivated. Physicians have volunteered for service all over the world, but charity begins at home.

If free clinics are proposed in your community, the contribution of a few hours of your time would enhance the image of medicine. —VSF

Lay midwives

THE WISCONSIN STATE JOURNAL, a Madison newspaper, recently featured an article about problems that had arisen with lay midwives.

In one case a frantic father called the Madison paramedics and ambulance because his wife was having a baby at home aided by a lay midwife and was in trouble. They found the mother squatting over a pan bleeding profusely and the baby wrapped in a blanket lying on the floor. The lay midwife screamed at the paramedics that they should get out, were not needed, and were not wanted. However, they did retrieve the baby and gave it resuscitation enroute to the neonatal intensive care unit. The paramedics noted that the child's umbilical cord had been cut and tied but that the baby was rolled up in blankets and apparently there had been no effort by the midwife to give it CPR. When a second ambulance was dispatched for the mother, the midwife refused to let them enter the house. Unfortunately the infant died of neonatal asphyxia despite the heroic efforts at the hospital.

In another case where the ambulance was summoned, the paramedic found that the placenta had delivered first and the baby finally delivered with the

umbilical cord wrapped around its neck. Again the cord was cut and tied by the time the paramedics arrived, and the baby was wrapped in blankets. Again it did not appear that the midwife was performing CPR. In this case the baby did survive, but it was still too early to determine if there was permanent brain damage.

On at least three other occasions ambulances had been called in rural Dane County to transport home-birth babies to hospitals.

Attempts were made to interview several of the midwives. One of them stated that she had "caught" 70 to 80 babies, and she had learned midwifery at a California birth center and considered herself well-trained after nine months. This same midwife said she chose to be unlicensed and never will seek licensure. Wisconsin began licensing nurse-midwives on January 1. These are registered nurses who have completed a special one- to two-year course in midwifery and are certified. There are about 25 licensed nurse-midwives in the state, mostly in La Crosse and Milwaukee.

The lay midwives are practicing medicine without a license. Freedom of choice of the care that anyone desires is a way of life, but it must be legal. The State Medical Examining Board must take action in the situation of the lay midwives before there is further loss of life. —VSF

Unprofessional conduct

WATCHING THE United States Senate struggle as it tried to decide whether a senator's acceptance of a bribe was really all that unethical was a truly disturbing experience. One can only wonder what they'd have done if Senator Williams hadn't finally resigned.

Have our leaders grown so immoral that they can no longer see the difference between right and wrong?

And if they do really know right from wrong, do they have the courage to follow the guidance of their consciences when painful courses have to be followed?

When the people who make the laws don't know right from wrong, what kind of laws will they enact?

Can we trust our legislators to act for the good of our country, or must we accept as fact the knowledge that when important decisions are to be made they will choose a course which leads to their greatest professional gain?

On the local front, at least three bills are now in the hopper which would declare certain acts by physicians to be unprofessional conduct. It would appear that our state Legislature, if it follows the United States Senate's lead, would have difficulty defining unprofessional conduct. —WJB■

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State Life Insurance Fund

IN 1911 THE State of Wisconsin enacted legislation forming the State Life Insurance Fund. This is a life insurance company under the direct management of the Commissioner of Insurance. At the present time any citizen of Wisconsin may buy up to $10,000 worth of insurance through this fund. Waiver of premium endorsement is automatic, and three options are offered: (1) dividends are applied to reduce premium, (2) dividends are left to accumulate, and (3) dividends are paid in cash.

This fund is available to physicians wishing to acquire $10,000 worth of life insurance. In today's economy $10,000 is not considered a large amount; however, it is cheaper than any other form of insurance available. For example, a 60-year-old with the ten-year renewable and convertible term life insurance policy through State Life Fund would pay a total premium of $49.30 for the year. Actually the insurance would cost him $249.80 but his dividends would be $200.50 on the $10,000 coverage.

The fund was established by the State of Wisconsin in order to determine what fair insurance rates should be. Over the years they have accumulated reserves which are so profitable at the present time that dividends used to reduce premium make State Life Fund insurance less expensive than any other.

Life insurance policies through State Life Insurance Fund are available to persons who are residents of the State of Wisconsin at the time the application is submitted. Seven different policies are available to residents who are standard risks. Residents who are substandard risks are only eligible for the basic ordinary life policy. Underwriting of substandard risks may require the fund to seek information from the Medical Information Bureau. This information will be obtained only if necessary. The fund is required by law to operate in a manner consistent with private insurers with regard to policy coverage, medical examinations, and underwriting procedures. Medical examinations are required of applicants over 45, and they are paid for by the fund.

Physicians wishing more information about State Life Fund should write to the Office of the Commissioner of Insurance, PO Box 7873, Madison, WI 53707. If you do not think you need more life insurance, this is an inexpensive way to help pay for probate costs of your local attorney. Insurance can be used as a fringe benefit for employees or as basic coverage for dependents.

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FWT-24 C-E-L

Letters

The Editors would like to encourage physicians to contribute to the LETTERS section where they can ventilate their frustrations as well as opinions. This feature is intended to be lively and spirited as well as informative and educational. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address correspondence to: The Editor, Wisconsin Medical Journal, Box 1109, Madison, Wis 53701.

Physician alert: A Munchausen patient in Wisconsin

TO THE EDITOR: In 1979 and 1980 a white male of about 40 years of age, claiming to be a truck driver, presented at various community hospitals in Wisconsin with complaints of kidney stones and Demerol® addiction; and following referral under different names, had two hospitalizations at University Hospital in Madison. In July 1981 and again in March of this year I had phone calls from other community hospitals about this patient, and because of his continued presence in Wisconsin, I thought that physicians should be alerted to his problem.

He gives a history of being from out-of-state and claims to have become addicted to Demerol® at age 18 as a result of its use for kidney stones. His 1980 admission to a community hospital before transfer to University Hospital was related to flank pain radiating to the right testicle, dysuria, blood in the urine, and a stone which he claimed he had passed. At that time he was getting Demerol® 150 mg intramuscularly every three hours.

On admission to University Hospital, straining of the urine yielded sandy gravel which was sent to an out-of-state analytical laboratory for urinary calculus analysis. The plan was to place the patient on tapering doses of oral methadone and to do retrograde urography. However, the patient refused to have any laboratory testing done, insisted on Demerol® injections, accused the nursing staff of disbelieving his symptomatology, denied a previous admission under another name, and eventually signed out against medical advice. The discharge diagnoses were: sociopathic personality, question kidney stones, question Demerol® addiction, and abuse of the hospital system by assuming an alias. The results of the urinary calculus analysis (received one week after discharge) showed obvious artifacts containing intermixed silicaceous matter with calcium carbonate.

In July 1981 this patient presented again with a similar story at another community hospital in Wisconsin and was given 50 mg of Demerol® at the emergency room and an additional 50 mg on the floor. However, the physician (who spent about two hours with him) tried to corroborate the story by making phone calls to Maine and Montana and found that the patient had left a trail of unpaid bills. The physician then phoned me seeking advice, and I recommended that the patient be referred to the University Hospital Emergency Room for a reevaluation of his problem. When the patient was confronted and given the recommendation for further evaluation, he left (without having had an overnight admission) and never showed up at University Hospital. He has since had another hospital admission elsewhere in Wisconsin leaving an unpaid bill of $3000.

This individual has an obvious problem, seemingly of a psychiatric nature, but there may be medical problems as well. If he is encountered again at a hospital emergency room, he should be directed to structured psychiatric and medical evaluation and care. While it is true that such individuals are difficult to help, and the prognosis is poor, attempts at appropriate support should be made.[1]

[1]Vaisrub S: The Immortal Baron (editorial). *JAMA* 230:90-91, 1974.

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Doctors! Look up from your scopes and viewboxes

TO THE EDITOR: The recent letters from Doctors Pawsat and Bauer about the "Role of the Nurse," reflect some of the ignorance, confusion, fear, and resentment building in the medical profession as we begin to feel some change in our role and position in society. At least three heavy-duty social changes have gotten underway in our culture recently while we physicians have been keeping our noses to the grindstone, eyes in our scopes, and stethoscopes in our ears.

First, the mandate for change in the way men and women relate has begun to have profound impact on doctor-nurse relationships. It is not just coincidental that doctors are mostly men and nurses mostly women! Second is the rapid movement toward an "expanded role" for nurses, manifest in the increasing opportunities for and numbers of Certified Nurse Practitioners and Clinical Nurse Specialists. Third, the medical profession meanwhile is right in the middle of an awestruck preoccupation with the "new technology" and related trends toward specialization and work by "procedure."

What does all this mean? I believe that nurses have only begun to enjoy some overdue recognition

of their rights and abilities, and that professionally they are quickly moving into a patient care void left by physicians who for now are finding the more objective aspects of medicine more attractive. The public has noticed for some time now that nurses are easier to talk to and seem to be "less busy." It seems not so off-the-wall-wild today to speculate that the Nurse Practitioner may become the major independent primary healthcare provider of the future, selectively referring patients to specialized and technically oriented physicians for procedures and establishment of protocols for medical management—kind of "Brave New World" in healthcare.

Not everything happening in the name of liberation and social change is desirable: Few would defend the nurse who in her new spirit of independence displays poor manners, disregard for proper group behavior, lack of respect for professional limitations, or lack of diligence in the performance of her job description. The same goes for doctors, as few would defend the doctor who will not be an enlightened participant in social change but rather asks to turn back the clock.

Doctors! Look up from the scopes and viewboxes, and remove those earpieces more often; see and hear what is happening around us! Our work is demanding and some preoccupation can be excused, but do we understand what is going on? Should we? How do we wish to participate in this clear and profound social change? How will we cope with the coming reduction in our professional role, social status, and incomes?

Norman M Jensen, MD
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A grateful patient

TO THE EDITOR: Recently the State Medical Society received a letter from a patient who wanted to express her gratitude for the dedication, care, and attention given her during a period of treatment by her family physician and the specialist to whom she was referred. The complimentary letter—a rarity in these days of perpetual criticism—included a poem which the Society would like to share with its members:

Earl R Thayer, Secretary
State Medical Society of Wisconsin

The horse and buggy days of old,
Have been laid to rest or so I've been told,
These were the days when "Doc" was best,
The caring "Doc" gave, was not taken in jest,

"Doc" came around with his big black bag,
Pulled by the old grey mare or another hag,
"Doc" had the cure for all aches and pains,
With true care and concern he made his greatest gains,

"Doc" was the best of family friends,
Whether it be body or soul that he attends,
He gave of himself in a professional yet personal way,
Yes, "Doc" is an enigma of long ago yesterday,

Today we have helped change "Doc" indeed,
He now belongs to a new medical breed,
Of busy professionals who have little time to give heed,
To the real human person "the patient" in need,

So with our new fancy technology,
There need be no apology, for the human touch
we've lost,
And with each new innovation,
We have great expectations, however we are paying
a good cost,

So even if we can't capture "Doc's" day and time,
We need not all feel so sublime,
For "Doc" is still combined in part,
Of the busy professional with a very kind heart.

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THE QUESTION OF

COMPUTERIZATION

NO. 2 OF A SERIES

The anatomy of a computer

John H Halton, MA, DPhil, FIMA, FBCS, Madison, Wisconsin

A *COMPUTER* IS A machine for the automatic processing of *information.* Historically, this information was numerical, and computers were machines for doing arithmetic. Unlike the simpler *calculating machines,* which can only perform one elementary arithmetic operation at a time, then need to be told what to do next (usually, by suitable button-pushes); computers can be given a list of operations to perform (often with branching and repetitions, depending on tests of sign or value included among the operations), and will then execute these in proper sequence without further intervention. This sequence of instructions is called a *program.*

A *digital computer* stores its information in the form of *words,* finite ordered sets of *digits,* each of which can only have one of a finite set of values. (This is analogous to the *decimal* representation of numbers, in which each digit takes one of the values 0, 1, 2, 3, 4, 5, 6, 7, 8, 9; or the written representation of English words, in which the 'digits' are the 26 letters of the alphabet.) Considerations of simplicity, reliability, and economy dictate that electrical engineers should design computers to consist of a great number of similar pieces of circuitry, each of which can only be in one of two states, usually denoted by 0 and 1. Such *binary digits* (or *bits*) are the elements of which computer digital representation is built. A row of eight bits is called a *byte,* and the majority of computers have their storage of information organized in words of one, two, four, or eight bytes (8, 16, 32, or 64 bits). The number of bits in a word is termed its *length;* if this is k, then the number of possible distinct pieces of information that can be stored in such a word is 2^k. In particular, four bits together can have sixteen different contents, and these are the standard *binary representations* of the numbers zero through fifteen:

0000=0 0001=1 0010=2 0011=3
0100=4 0101=5 0110=6 0111=7
1000=8 1001=9 1010=A 1011=B
1100=C 1101=D 1110=E 1111=F

with A=ten, B=eleven, C=twelve, D=thirteen, E=fourteen, and F=fifteen. These may now be viewed as the sixteen possible digits of a representation (the *hexadecimal,* or *hex*) which is much more compact and humanly-intelligible than a long string of zeros and ones. For example, the byte 10110010 becomes 'B2', and the four-byte computer word 01001100011100101101000-110001110 becomes the eight-digit hex word '4C72D18E'.

We now turn to Figure 1, which is a diagram of the various parts of which any computer is composed. These are, essentially,

(1) a *central processing unit* (CPU), which is the controlling and computing center of the machine;

(2) a *memory,* possibly of different levels, in which both *data* and *instructions* are stored; and

(3) a variety of *input* and *output* (I/O) *devices,* through which the machine communicates with the world outside it.

(1) The CPU consists of an *operation control unit* (OCU), an *arithmetic/logical unit* (ALU), and a relatively small, very-fast accessible *local memory* (LM). The OCU keeps track of the memory location of the next instruction to be executed, and analyzes the current instruction, so as to activate the proper operation of a memory transfer, non-sequential jump (by appropriately changing the address of the next instruction), input or output of information, or computation (performed by the ALU), as is indicated by the instruction code. The ALU actually carries out the elementary arithmetic operations (addition, subtraction or negation, multiplication, division or reciprocation) and logical operations (these being bit-by-bit operations, without carry, such as **not, and,** and **xor:** *eg,* **not** 1101=0010, 1100 **and** 0101=0100, 0110 **xor** 1010=1100) on the data given to it by the OCU. The LM receives the operands called for by the OCU and also the results of the ALU's operations upon them. For example, the OCU may re-

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trieve the factors of a multiplication from the main memory into a pair of LM registers and instruct the ALU to multiply them and place their product in another LM register. Such registers are usually called *accumulators,* and they are normally double-length (since the product of two k-bit numbers is a $2k$-bit number). Other LM registers are used for counting (*eg,* repetitions) and are called *index registers;* others hold intermediate values and are called *buffers;* and, finally, there are one-bit or two-bit registers which reflect the information on which tests are made by the OCU (for example, the occurrence of a carry, the vanishing or positivity of an answer, or the occurrence of an arithmetic overflow): these are termed *flags.*

Originally, the CPU was a sizeable piece of electronics, hand-assembled and highly complex. With the advent of micro-miniaturization of circuitry, printing and photographic techniques, and mass-production of components, only the largest computers (*main-frames*) are built in the old way. Smaller systems generally have the entire CPU on a single chip. Among these, the name *microcomputer* is now applied to those with less than a million words of memory and a word-length of one or two bytes; the name *minicomputer*

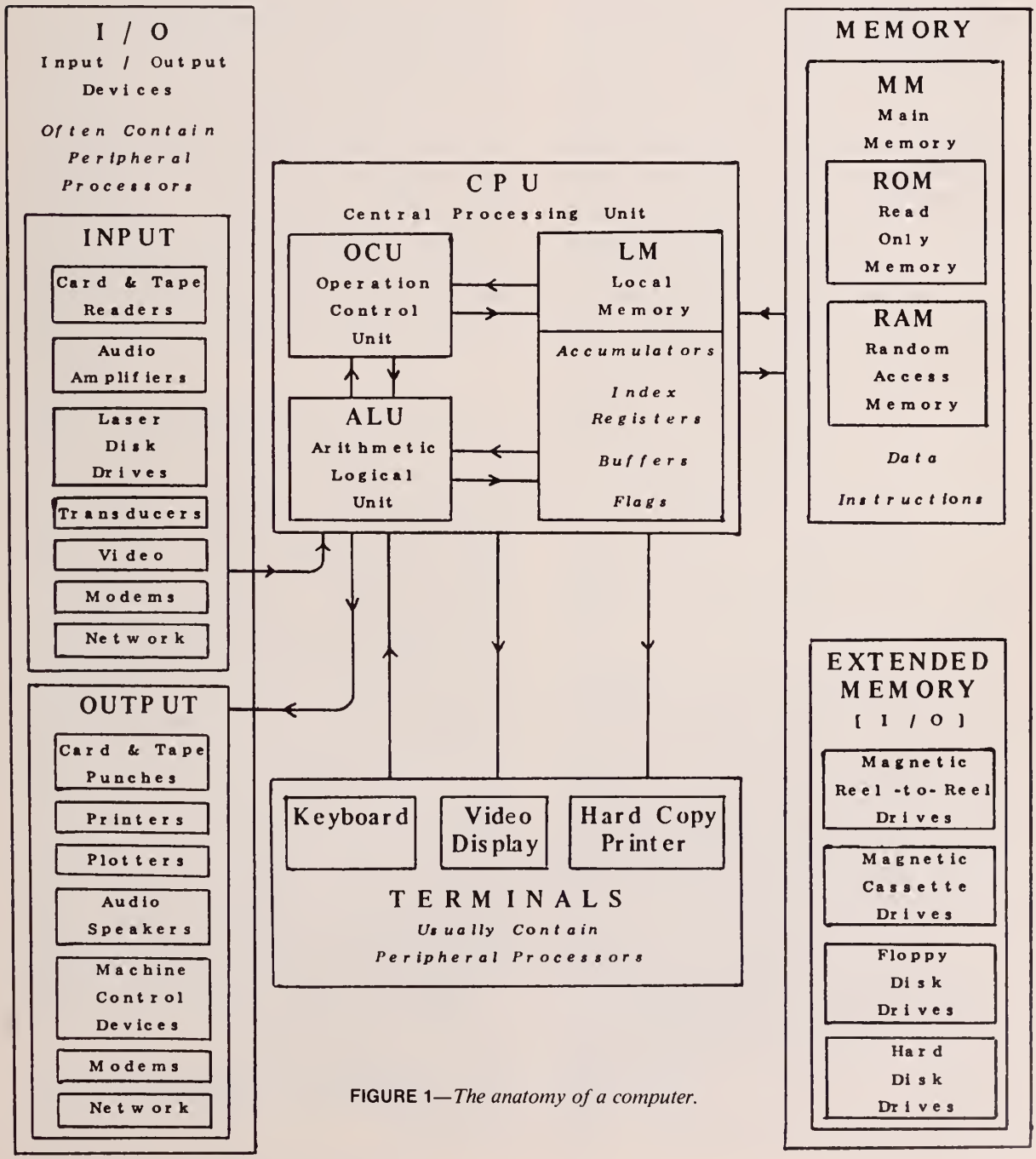

FIGURE 1—*The anatomy of a computer.*

applies to the larger machines, with two to four-byte words and one to a hundred million words of memory. [The smallest micro is probably more powerful than the big computers used by universities and industry in the 1950s.]

(2) The *main memory* (MM) consists of magnetic or electronic components which store the information (both data and instructions) needed by the computer. The individual words are directly *addressable* from the CPU by number (rather like houses in a street), and their contents are retrievable in very short times, of the order of the operation time of the CPU (ranging from fractions of a *nanosecond,* 10^{-9} or one billionth of a second, for the fastest main-frames, to several *microseconds,* 10^{-6} or millionths of a second, for the slower micros). This is often referred to as *high-speed storage* or *random-access memory* (RAM). While most of the MM is erasable and may be changed at will, some memory is used to store constants and often-used utility programs and is not erasable by the CPU: such memory is called *read-only memory* (ROM). Sometimes this is optional and can be plugged-into the computer: this is called *firmware.*

Note that a computer with one-byte-long addresses can have at most $2^8 = 256$ words of MM; a two-byte address can reach $256^2 = 65536$ words; a three-byte-long address can select any of 16777216 words of MM, and so on. In practice, most micros and minis have MM ranging in size from $2^{14} = 16384$ to $2^{18} = 262144$ words. It should be noted that $10^3 = 1000$ and $2^{10} = 1024$. Because computers are so heavily slanted towards base-2 representation, it has become almost universal computer parlance to use the prefix *kilo* or K (which usually denotes a thousand units) to denote 1024 and the prefix *mega* or M (which usually denotes a million units) to denote $2^{20} = 1024^2 = 1048576$. Thus, we write 16K for 2^{14} and ¼M for 2^{18}. Perhaps the commonest size of MM consists of 64K = 65536 words.

Almost all computer instructions comprise an *operation code* (usually one byte long, allowing 256 possible operations to be specified), followed by an *operand reference* (a number, index, or address) of variable length (since some operations require more data than others; for instance, the STOP instruction needs no operand, so it is one byte long).

The *extended memory* (EM) is sometimes considered under I/O devices, both because it is often physically located outside the computer (while the CPU and the MM are usually in the same enclosure), and because its speed of access is much slower than the speed of operation of the CPU and is comparable with the range of speeds of I/O devices. Most read/write memory is magnetic [optical memory is read-only, and fast RAM is either magnetic or electronic], either in the form of *tape, drum,* or *disk,* coated with magnetic material, much like sound-recording equipment; it is similarly erased, read, and recorded upon by 'heads' which contain electromagnetic sensors/polarizers. The cheapest (and most limited, in both speed and capacity) device is a common portable cassette recorder, with ¼" tape cassettes. From this, one moves to specially engineered cassettes and recorders, and thence to high-speed ½" or 1" reel-to-reel drives carrying thousands of feet of tape at very high speeds. Access times can be quite good for *sequential* access, along the tape, but *random access* time is poor at best, running to seconds or even minutes. Economy and a virtually unlimited total storage capacity (on numerous cassettes or reels; but only as many units as one has on-line tape-drives are actually accessible without human intervention) are the only advantages.

When we wish for practically useful EM, combining large capacity with relative economy and speed of random access, we must turn to *drum* or *disk memory;* and, nowadays, the former have been practically replaced by the latter. Disk memory is of two types: *floppy disk* and *hard disk,* the first being the cheaper, slower, smaller-capacity option. Floppy disks are flexible, have diameters of 5¼" or 8", generally, and are removable from the disk-drive, so allowing one to build up an unlimited *library* of stored data. The information is stored on concentric circular *tracks* [not on a single spiral track, as on a sound record] on one or both sides of the disk. The number of tracks and the number of bytes per track vary (the density increasing with precision of engineering, and so with cost of the drive), but the total capacity of a floppy disk is in the range of 50KB to 1MB. The disks rotate at, typically, 300 rpm, and access time is governed by the time required to place the *movable head* on the right track, a fraction of a second, plus the fifth of a second taken by the head to traverse the circumference of the track, in search of a record; thereafter, consecutive bytes are accessed at some thousands per second.

Hard disks are rigid and have larger diameters. There are drives with anything from one to a dozen disks, rotating at about ten times the speed of floppy-disk drives (and so diminishing the access-time of records in a track), with one or several heads. *Fixed-head* drives naturally must have a head for each track (which costs more), but save head-movement time in random access. *Winchester* disks are movable-head drives with sealed-in disks, in which the heads ride very close to the disk, cushioned by the layer of air between. In floppy-disk drives, the head actually rides on the disk, eventually wearing it out. The capacity of hard-disk drives ranges from 10 MB to 100 MB in a single drive. Some movable-head hard-disk drives have removable disks or disk-packs, allowing for greater library storage.

The next article will examine the various I/O devices and the external communications of the computer.■

Laparoscopic evaluation of hepatic and peritoneal disease. . .

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APPRECIATION OF THE value of laparoscopy in internal medicine has lagged behind the widespread popularity of this procedure in the gynecologic community. However, there has been increasing interest in gastrointestinal laparoscopy because of its advantages compared with other procedures to evaluate possible hepatic or peritoneal disease. Laparoscopy can be performed safely with intravenous sedation and local anesthesia, and it provides clear visualization and directed biopsy of intraabdominal organs. Because of these considerations, we began performing laparoscopic examinations in our gastrointestinal diagnostic unit in 1975. In this report we summarize our experience with the first 183 medical laparoscopies at the University of Wisconsin-Madison.

PATIENTS AND METHODS. Between April 1975 and June 1979 we examined 183 patients ranging in age from 16 to 88 years. The primary indication for the procedure was suspected hepatic metastases (Table 1). All procedures were performed in an endoscopy room equipped with a four-directional tilt table. The abdomen was shaved and scrubbed the evening prior to the exam. Paracentesis of 1 to 3 liters of fluid was performed as necessary in patients with tense ascites. Patients were premedicated with intramuscular meperidine (Demerol®) (50 to 100 mg); most also received atropine 0.6 mg. (More recently, oxygen is routinely provided at a rate of 2 l/min throughout the examination and a nasogastric tube is inserted to decompress the stomach.) At the time of the examination, intravenous diazepam (Valium®) (2 to 30 mg) was administered to achieve a state of cooperative somnolence. Additional diazepam was given during the examination as necessary. The abdomen was scrubbed with povidone-iodine and alcohol and draped. Sterile technique was used throughout. A trocar insertion site was usually chosen 4 cm to the left and cephalad of the umbilicus. Alternative sites were chosen as necessary to avoid abdominal scars.

Local anesthesia at the puncture site was induced with 1% lidocaine (Xylocaine®). The peritoneum was punctured with a Verres needle and pneumoperitoneum achieved with nitrous oxide (2-4 l) under manometric control. The presence of a free pneumoperitoneum was determined by the free return of gas bubbles at aspiration from a generous area beneath the intended trocar insertion site. A trocar sleeve was inserted and the abdomen examined with a Wolf 10 mm, 180° telescope. An accessory trocar was usually inserted under direct vision in the right upper quadrant. This allowed use of a probe with which to lift and palpate the liver and manipulate the omentum and bowel. Biopsy of the liver was performed under direct vision with a Jacobs suction needle; usually 2 to 4 biopsies were taken. Peritoneal biopsies were obtained with a spoon-shaped forceps. Bleeding from liver biopsy sites usually ceased spontaneously. Rarely, persistent bleeding required electrocoagulation of the biopsy wound. At the conclusion of the exam the instruments were removed and the insertion sites inspected, sutured and dressed. All patients were observed on a medical floor overnight.

RESULTS. The intended examination was unsuccessful in 13 patients (7%), 11 in the group with suspected hepatic metastases and two in the group with lymphoma. One patient had a hypotensive episode during preparation which prompted cancellation of the examination. The other 12 patients had dense intraperitoneal adhesions which prevented the induction of a satisfactory free pneumoperitoneum.

Previous abdominal operation could interfere with a thorough laparoscopic examination depending upon the location of the surgical scar. Infraumbilical scars in 16 patients had no effect on liver

TABLE 1—*Indications for laparoscopy in 183 patients*

INDICATION	NUMBER OF PATIENTS (%)	
Suspected hepatic malignancy	113	(62)
Lymphoma staging	48	(26)
Unexplained ascites	11	(6)
Benign liver disease	11	(6)

From the Department of Medicine, University of Wisconsin-Madison Medical School. Publication support provided. Reprint requests to: Lane A Kistler, MD, 10401 West Lincoln Ave, West Allis, Wis 53227 (phone: 414/545-7213). Copyright 1982 by the State Medical Society of Wisconsin.

TABLE 2—*Visual laparoscopic diagnosis in 100 patients successfully examined for hepatic malignancy*

Negative for Malignancy	Positive for Malignancy
61	39

TABLE 3—*Evaluation of liver scans*

	Final Diagnosis	
Liver Scan Interpretation	Negative for Malignancy	Positive for Malignancy
Normal	11 (73%)	4 (27%)
Diffusely abnormal	15 (75%)	5 (25%)
Focal abnormality	28 (45%)	34 (55%)
	54	43

examination. In nine patients with a cholecystectomy scar, a veil of adhesions interfered with examination of the right hepatic lobe in seven. Laparotomy scars were present in 44 patients; diffuse adhesions prevented a free pneumoperitoneum in ten (23%). The examination was possible but incomplete in 12 (27%), but was complete in the remaining 22 (50%). Although adhesions could compromise the thoroughness of the liver examination, evaluation of abnormal areas suggested by liver scan was usually successful.

Suspected hepatic malignancy. Results in 100 patients successfully examined for hepatic malignancy are presented in Table 2. The visual diagnosis of hepatic malignancy in 39 patients was confirmed by biopsy in 38. A single patient had typical hepatic metastases seen at examination, but the patient had been uncooperative during the procedure and the usual biopsies had not been possible. Metastatic disease was confirmed at laparotomy.

In addition, there were two patients with hemangioma. The first was diagnosed visually as a benign hemangioma at laparoscopy. The laparoscopist was uncertain if the second patient had a benign or malignant hemangioma; the diagnosis was confirmed at laparotomy.

Of the 61 examinations considered negative for malignancy, there was some followup available in 34 cases. Eight cases went to surgery within several days of the examination and one patient came to postmortem within a month of the examination; none had evidence of metastatic liver disease. One patient with small cell carcinoma of the lung was found to have liver metastases at autopsy five months after laparoscopy. This tumor has a notoriously rapid growth pattern and the original examination may have been truly negative. Twenty-four patients had clinical followup ranging from 1 to 36 months (mean 8 months). On the basis of followup, 21 were judged to have probably been free of hepatic malignancy at the time of the examination. Two were judged to have probably had hepatic metastases and one patient was considered indeterminate.

These three patients and the patient with small cell carcinoma of the lung could be considered false negative examinations. Therefore, there were 43 patients with hepatic malignancy. Laparoscopy correctly diagnosed 39. So, the sensitivity of the procedure in our hands was 91% and the negative predictive value was 93%.

These examinations were often performed because of abnormalities found on liver scan. We found liver scanning to be a sensitive but not very specific test for hepatic metastases (Table 3). The specificity of liver scanning was only 20%; that is, 80% of our patients negative for hepatic malignancy had an abnormal liver scan. The sensitivity of the test was 91%. If focal abnormalities alone were considered a positive liver scan, the specificity was increased to 48% but the sensitivity was reduced to 79%. The high number of false positive scans in this series is partially explained by the presence of benign hepatic cysts in five of our patients and by the frequent occurrence of anatomic variations.

Lymphoma staging. Forty-eight patients underwent laparoscopy to evaluate possible hepatic involvement by lymphoma. Two patients had unsuccessful examinations and one patient had a successful negative examination, but was later diagnosed as having a benign white cell disorder. Our results in 45 patients successfully examined for lymphoma are presented in Table 4. Nine patients with Hodgkin's disease underwent staging laparoscopy. No cases of hepatic involvement were found. Four of these patients went on to formal surgical staging; none was found to have hepatic lymphoma. Twenty patients with non-Hodgkin's lymphoma underwent staging laparoscopy. Of the 19 patients with negative examinations, two were confirmed as negative at surgery and one at autopsy. One patient was thought to have hepatic lymphoma visually at laparoscopy, but biopsy showed only capsular fibrosis. Clinical followup suggested that the liver had been negative at the time of the examination.

TABLE 4—*Visual laparoscopic diagnosis in 45 patients successfully examined for lymphoma*

		Number of Patients	Negative for Lymphoma	Positive for Lymphoma
Hodgkin's	Staging	9	9	0
	After treatment	7	6	1
NonHodgkin's	Staging	20	19	1
	After treatment	9	8	1
		45	42	3

The major indications for laparoscopy in patients already undergoing treatment included changes in clinical status and assessment of response to therapy. Most of these examinations were also negative. Biopsy confirmed the visual impression of hepatic involvement in a patient with nonHodgkin's lymphoma. A patient with Hodgkin's disease was also thought to have hepatic disease at examination but biopsies were negative. This patient had had hepatic involvement at laparotomy seven years previously, so the visual impression may have been accurate.

Ascites. The 11 patients in this group were studied because of exudative or hemorrhagic ascites. Seven patients were found to have peritoneal carcinomatosis. Many of these had undergone lengthy inconclusive medical evaluations prior to laparoscopic diagnosis. Three patients had cirrhosis confirmed as the sole cause of their ascites. One patient with chronic renal failure, with a normal liver and peritoneum at laparoscopy, was diagnosed as having hemodialysis ascites.

Benign liver disease. These 11 patients were examined for a variety of reasons: unsuccessful percutaneous liver biopsy, concern regarding sampling error of percutaneous biopsy or concern regarding possible complications thought preventable by directed laparoscopic biopsy. Final diagnoses included cirrhosis, of both alcoholic and nonalcoholic origin, chronic hepatitis, granulomatous arteritis involving the liver, primary biliary cirrhosis and nodular regenerative hyperplasia.

COMPLICATIONS. There were no deaths and only one major complication (0.5%) in this series. The major complication occurred in a patient who suffered a brief grand mal seizure at the time of trocar insertion. He subsequently evolved a completed, presumably embolic stroke. Another patient developed transient hypotension during peritoneal insufflation. Neither of these patients had received atropine. Such complications have not occurred since atropine and nasal oxygen have been routinely used. A single patient who had unrecognized extrahepatic bile duct obstruction developed bile peritonitis following liver biopsy but responded to medical management. There were two episodes of bleeding from the trocar insertion site which were controlled with suture. No patient required surgical intervention as a consequence of laparoscopic complication.

DISCUSSION. As in previous reports, the primary indication for laparoscopy in our series was the clinical suspicion of hepatic metastases.[1,2,3] We found successful laparoscopic examination to be highly sensitive (91%) in this group of patients. Our results compare favorably with previous series. Bleiberg and coworkers[4,5] reviewed the results of laparoscopy in 75 patients who had either surgical or autopsy evaluation of the liver within two months of a successful laparoscopic examination. The overall sensitivity of the examination was 89%. The Memorial Sloan-Kettering experience was similar with a sensitivity of 92% in 65 patients with hepatic malignancy.[6] The sensitivity of laparoscopic examination is a reflection of the large surface area available to laparoscopic inspection and of the multiple biopsies which can be obtained under direct vision. Also, focal lesions difficult to biopsy by percutaneous approach, such as those in the left lobe, are easily sampled at laparoscopy.[7]

There are limitations to laparoscopic examination. Some 10% of patients with hepatic metastases do not have visible lesions on the liver surface when examined at autopsy.[8] Surface lesions can also be missed at laparoscopy if they are situated very laterally or superiorly in the right lobe or if they are hidden by adhesions. Some of these lesions will be diagnosed laparoscopically by random or scan-directed biopsy.[6] Adhesions can be avoided by choosing an insertion site likely to provide maximal visibility of probable areas of disease as determined by scan, and on occasion, holes in adhesive bands allow adequate examination of the liver behind. So, frequently adhesions are less a problem than might be anticipated.[9,10] The risk of potential complication is higher in persons with adhesions and we agree with previous recommendations that the trocar insertion site be kept 5 cm away from abdominal scars.[10]

Despite such drawbacks, laparoscopic liver biopsy is far more sensitive than blind percutaneous biopsy. The sensitivity of percutaneous biopsy obtained at autopsy in persons with metastatic disease was 43%. The yield in this study increased to 58% if subcostal biopsy of the left lobe was also performed.[11] However, few clinicians perform subcostal biopsy because of the increased risk of complications. Newer approaches, such as computerized tomographic (CT) scan-directed biopsy of focal lesions, need further evaluation.[12]

We also were able to evaluate the accuracy of liver scanning in our patients, and found it to be a sensitive but nonspecific test. In a similar study, Lightdale and colleagues[6] demonstrated an 80% sensitivity and 71% specificity of liver scans. Our impression is that the specificity of scanning is increasing at our institution because of increased use of ultrasonography to identify hepatic cysts and anatomic variations. Scans do help in deciding whether to attempt a percutaneous biopsy prior to laparoscopy. If the scan defect is located laterally in the right lobe, we usually do perform a percutaneous biopsy first. If the defect is in the left lobe, then laparoscopy is our procedure of first choice.[7]

Our results in patients with lymphoma are also similar to previous reports.[13,14,15,16] Liver involvement in Hodgkin's disease is comparatively infrequent; but, if present, obviates the need for staging laparotomy.[13,14] All nine of our patients studied as part of pretreatment evaluation had negative laparoscopic examinations. In an Italian series, only one of 55 patients with a negative laparoscopic examination had hepatic involvement at laparotomy.[13] In a study from

the National Cancer Institute using both blind percutaneous biopsy and laparoscopy, the incidence of positive findings was similar to an historical review of laparotomy results.[14] Thus, laparoscopic staging is rapidly becoming an integral part of the pretreatment evaluation of these patients.

In contrast to Hodgkin's disease, nonHodgkin's lymphoma frequently involves the liver.[14,15,16] Laparoscopy has been found to be 79% sensitive in this disease.[15,16] By comparison, percutaneous biopsy was only 44% sensitive.[16] We had one false positive visual diagnosis in our series. Probably this is because one of the principal patterns of hepatic involvement by lymphoma is that of minute white papules on the liver surface. This appearance can be mimicked by areas of focal capsular thickening or granulomatous reaction which can be mistaken for lymphoma.

Even enthusiasts of computed tomography admit that laparoscopy is the best way to diagnose peritoneal disease without resorting to laparotomy.[12] Both peritoneal malignancy, mesothelioma as well as metastatic tumor, and nonmalignant disease, such as tuberculous peritonitis, can be identified with certainty.[17,18,19] The major indication that peritoneal disease is present is unexplained exudative or hemorrhagic ascites. Laparoscopy has a high yield in this situation.[17]

The indications for laparoscopy in the diagnosis of diffuse, benign liver disease are less well defined. Because of fragmentation, cirrhosis can be missed with percutaneous suction biopsy in as many as 30% of patients.[20] Also, there is a sampling error with percutaneous biopsy in the assessment of chronic hepatitis.[20,21] The multiple biopsies from different areas of the liver made possible by laparoscopy help to overcome these problems. In addition, a visual diagnosis of cirrhosis at laparoscopy is accurate enough to avoid liver biopsy in patients with abnormal coagulation.[22] However, the most reasonable indication for laparoscopy in patients with benign liver disease remains failure of percutaneous biopsy.

We were delighted with our low complication rate, particularly since this series begins with our first patient. None of our patients died and none required surgical intervention as a result of the procedure. Our complication rate is likely to be reduced by the routine use of oxygen and atropine. Our patients tolerated laparoscopy well with local anesthesia and intravenous sedation. They were often amnestic for the entire procedure. In addition, the usual recovery time was less than 24 hours. We had no infections even though the procedures were performed in an endoscopic room rather than an operating room. Laparoscopy is indeed a safe, comfortable procedure when performed in this manner.[3,6,17,23] However, it should be performed by a trained gastroenterologist or surgeon.

SUMMARY. We found laparoscopy to be an accurate test for hepatic and peritoneal disease. It clearly offers significant advantages when compared with other currently available techniques. We were impressed with its safety when performed by trained physicians and the ease with which our patients tolerated the procedure. The time has come for laparoscopy to be accepted by the internal medicine community as a helpful diagnostic procedure.

GLOSSARY OF TERMS

Sensitivity: Probability that test or procedure result will be positive when the disease is present.

Specificity: Probability that test or procedure result will be negative when the disease is not present.

Negative Predictive Value: Probability that the disease is not present when the test or procedure is negative.

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Intrapartum fetal death associated with propranolol; case report and review of physiology

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PROPRANOLOL (Inderal®) is a widely used beta adrenergic blocking agent. Clinical applications include its use in thyroid disease, cardiac arrhythmias, elevated blood pressure, angina pectoris, and hypertrophic cardiac disease.[1] Effects on the fetus of the use of propranolol during pregnancy only recently have been reported.[2] Hypoglycemia, bradycardia, and intrauterine growth retardation have been among the perinatal effects already reported. We report a case of growth retardation and intrapartum fetal death associated with propranolol.

CASE REPORT. A 29-year-old white female gravida 3 para 2 with an estimated date of confinement of December 9, 1977, was admitted to the labor unit on December 23, 1977. Her obstetric history included normal spontaneous vaginal deliveries of appropriate-for-gestational-age twin male infants in 1966, and a singleton female 3890-gm infant in January 1973. Her medical history was completely unremarkable until August 1973 when she experienced palpitations diagnosed by history only as paroxysmal atrial tachycardia, and she was started on propranolol, 80 mg daily. In 1975 propranolol was increased to 120 mg daily and digoxin 0.25 mg daily was added to relieve persistent reports of palpitations. In November 1977, during the eighth month of her pregnancy, propranolol was increased to 240 mg daily by her cardiologist.

On admission to the labor unit the patient was in early labor with the cervix dilated 1.0 cm, 60 percent effaced, membranes intact, with a vertex presentation at a -2 station. External fetal and uterine monitors showed a baseline heart rate of 100-110 beats per minute (bpm), decelerations with contractions to 70 bpm, and slow heart rate recovery to an erratic baseline. Mother was placed on her side and given oxygen. A Cesarean section delivery was considered, and a scalp electrode was placed to obtain an improved baseline tracing. Artificial rupture of the membranes for placement of the scalp electrode yielded scant amniotic fluid. Immediately after placing the electrode the fetal heart tracing showed a rate of 70 bpm with recovery over two minutes to 110 bpm. The next mild uterine contraction initiated a deceleration to 60 bpm which did not recover. The mother adamantly refused intravenous administration of isoproterenol (Isuprel®) or atropine for treatment of fetal intrauterine cardiac betaadrenergic blockade. Forty minutes later, a stillborn 2670-gm female infant was delivered vaginally under local anesthesia. The infant was covered with dark green-brown thick meconium. The trachea was suctioned yielding copious amounts of meconium before vigorous resuscitation efforts could be made. The initial Apgar score was zero, and resuscitation efforts were not successful.

Autopsy showed no congenital anomalies. The baby was small-for-gestational-age and the placenta was also small, weighing 370 gm, but showed no evidence of infarction or abruption at delivery. Fetal digoxin level was 1.6 mg/ml but propranolol level was not available. Final diagnosis was a small-for-gestational-age fetus with intrauterine anoxia of undetermined etiology.

DISCUSSION. The use of propranolol in nongravid adults is well-known, but its use only recently has been extended to pregnant individuals for hypertension,[3] arrhythmias,[4] hyperthyroidism,[5,6,7] and hypertrophic obstructive cardiac disease.[2,8] It has been postulated that continuous administration of propranolol throughout pregnancy may block uterine beta-receptors causing uterine hypertonicity and small-for-gestational-age (SGA) infants.[4] The direct fetal effects noted in recent reports include impairment of the autonomic nervous system,[9] bradycardia,[3,10] hypoglycemia,[3,10] and respiratory depression.[11,12]

Blockade of uterine beta-adrenergic receptors which normally mediate uterine relaxation has long been known to result in chronic myometrial stimulation, and propranolol has even been successfully used to terminate pregnancy.[13] Reed and associates[4]

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have suggested that the chronic administration of propranolol throughout pregnancy causes increased uterine tone resulting in decreased uterine blood flow, decreased placental size, and producing SGA babies. The SGA infant reported here was 1220 gm smaller than the normal infant produced by this mother before her propranolol therapy began.

There is abundant evidence that maternally administered propranolol readily crosses the placenta in the human.[7,12] Once in the fetus, propranolol has been shown to cause effective beta-adrenergic blockade in humans[9] and in experimental animals.[14,15] Renou, et al[9] showed that 10 mg of propranolol given to a mother intravenously caused a significant slowing of the fetal heart.

The fetal heart rate and beat-to-beat variability appear to be directly influenced by the autonomic nervous system which is known to be actively functioning as early as the beginning of the third trimester of fetal life. There is also evidence that intact autonomic control of the cardiovascular system is necessary for the fetus to withstand the stress of labor and delivery. Joelsson[15] subjected unanesthetized fetal sheep to anoxic stress by clamping their umbilical cords. Fetuses with intact autonomic nervous systems responded to cord clamping with transient tachycardia, then bradycardia. Following release of the cord clamp, the intact fetuses were able to elevate their blood pressure and mount a compensatory tachycardia. But fetal sheep premedicated with propranolol responded to the same anoxic insult with bradycardia and a fall in blood pressure. Following cord release, their ability to mount a tachycardia was abolished.[14] Thus it becomes apparent that impairment of the fetal autonomic nervous system may seriously jeopardize the fetal ability to cope with anoxic insults. The human fetal heart rate responses reported here were similar to those seen in fetal sheep given propranolol before cord-clamping.

But impairment of the fetal autonomic system is only one of several deleterious effects possibly attributable to propranolol. There have been several recent reports linking maternal propranolol administration to adverse postpartum conditions of the newborn including continued bradycardia[3,4,10] and hypoglycemia.[12]

If a postpartum fetal bradycardia occurs, it almost uniformly lasts three to four days. This is much longer than expected considering the time required for complete recovery from chronic propranolol therapy in the adult is 48 hours.[16] But as Cottrill[12] points out, the half-life of propranolol in the newborn may well be prolonged. Immaturity of the fetal hepatic microsomal enzymes, decreased liver blood flow, and altered binding to plasma proteins may be responsible for a prolonged perinatal half-life of propranolol. Cottrill[12] reported an infant who had an umbilical artery propranolol level of 36 ng/ml at delivery. Four hours later the neonate had a plasma level of 90 ng/ml indicating either drug redistribution or perhaps that the infant depended heavily on a maternal excretion route *in utero*.

There is some evidence that propranolol may also inhibit respiration. In a double blind study Tunstall[11] administered 1.0 mg of propranolol intravenously to mothers shortly prior to Cesarean section. Propranolol caused a highly significant ($p < 0.001$) prolongation of the time-to-sustained respiration (TSR) in the neonates.

As Cottrill[12] has previously noted, the severity of effect on the fetus or newborn may be a dose-related phenomenon. When maternal propranolol was administered in total dosages less than 90 mg/day orally, most reports show no untoward fetal effects, or only mild postpartum hypoglycemia and bradycardia.[1,7,15] But other reports[5,10] citing propranolol dosages of at least 160 mg/day note growth retardation, profound intrapartum bradycardia, low Apgar scores, severe postnatal hypoglycemia, and persistent bradycardia.

SUMMARY. This case involved an intrapartum fetal death occurring in association with chronic maternal propranolol therapy of 240 mg/day. A healthy nonsmoking mother, who had produced three previous infants appropriate for gestational age, produced a small-for-gestational-age fetus while taking propranolol for control of her palpitations. The fetal heart rates during labor were consistent with a high degree of beta-adrenergic blockade.

Although growth retardation, bradycardia, hypoglycemia, and depressed respiration have been previously reported in association with propranolol, the impairment of the fetal autonomic nervous system and intolerance to the stress of early labor have not been emphasized. We believe this case may illustrate the inability to recover from hypoxic stress which should be expected in a fetus exposed to high-dose propranolol throughout pregnancy.

Indications for propranolol must be reexamined when pregnancy occurs, and the possible risk for the fetus weighed thoughtfully against the need for continued maternal beta-adrenergic blockade. Perhaps tapering of the maternal doses of propranolol near delivery should be considered as was done in the case reported by Datta, et al.[2] It must be remembered by all physicians who deal with pregnant patients that the myometrium has alpha-stimulatory and beta-relaxant receptors which can be affected by cardiac and vasoactive drugs. In addition, there is firm evidence, reviewed in this article from clinical experience and laboratory research, that the fetal autonomic system and cardiovascular system will also be affected by high doses of beta-blockers given to mothers.

Certainly continuous intrapartum fetal monitoring is indicated in every propranolol pregnancy to detect the first signs of fetal distress. If distress is indicated, delivery must be accomplished immedi-

ately since these infants may be unable to withstand or recover from normal stresses. The attending personnel must be knowledgeable about the consequences of fetal/newborn beta-adrenergic blockade, and the nursery alerted to the possibility of continuing hypoglycemia and persistent bradycardia in such neonates.

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Perinatology

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Are calcium supplements required during pregnancy?

Frank R Greer, MD, Madison, Wisconsin

Editorial Note: ***It has been clearly established that pregnant women must supplement their diet with iron in order to meet the increased demands for that mineral. It is not clear, however, if other minerals need be supplemented. The following article discusses some aspects of calcium metabolism during pregnancy and provides evidence to guide the obstetrical practitioner in discussing calcium needs with his patients.*** —LBC

OF MOTHERS ADMITTED to the obstetrical service of Madison General Hospital, 95% take prenatal vitamins at sometime during their pregnancy, supplying 10%-20% of the daily recommended dietary allowance (RDA) of calcium. An additional 30% are taking further calcium supplements. Is there evidence to support the necessity of maternal supplements of calcium above the "normal" (nonpregnant) recommended dietary intake? Or, are there physiologic mechanisms that allow maternal adaptation to the increased calcium requirements of pregnancy making such calcium supplements unnecessary? This paper will examine these questions.

Approximately 98% of the 1100-1200 Gm total body calcium in the adult is present in the skeleton as hydroxyapatite. The calcium contained in the bone is in a continuous state of flux, as much as 700 mg entering or leaving the bone daily. Of the total serum calcium concentration, approximately 45% is protein-bound and 47% is ionized or free. The remaining small percentage exists as citrate and phosphate complexes.[1] At the end of the first trimester, the fetus has a total body calcium content of 0.1 Gm and by the end of pregnancy it contains 25-30 Gm of calcium, which represents 2% to 3% of the total maternal body calcium.[1] The majority (70%-80%) of the fetal calcium is accumulated during the last trimester of pregnancy with a placental transfer rate as high as 150 mg/kg/day.[2]

Table 1 lists the current RDA for calcium in pregnant and nonpregnant women of childbearing age.[3] In the pregnant mother the additional requirement of 400 mg of calcium/day over the 280 days of pregnancy would result in a calcium intake of 112 Gm above the recommended nonpregnant intake over

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TABLE 1—*Recommended daily dietary allowance for calcium in women of childbearing age.*

Age (years)	*Non-pregnant (mg)*	*Pregnant (mg)*	*Lactating (mg)*
11-18	1200	1600	1600
19-50	800	1200	1200

the same time period. As the fetus only requires 25-30 Gm of calcium, such intake would greatly exceed the fetal requirement. Assuming a maternal intestinal absorption rate of only 50%, there would still be an excess calcium intake.

Why is there such a high RDA for calcium in pregnant women? In the first place, early literature described decreased serum calcium levels during pregnancy resulting in attempts to prevent maternal calcium depletion during pregnancy. Subsequent studies have shown that the decrease in total serum calcium concentration during pregnancy is largely secondary to a decrease in total maternal serum protein concentration[1] with very little change in the concentration of ionized calcium. Secondly, there have been observations describing osteomalacia among pregnant women in China.[4] And finally, short-term balance studies have demonstrated positive calcium balance during pregnancy in patients receiving calcium supplements, thus encouraging the routine use of calcium supplementation.[5] However, the possibility that maternal physiologic adaptations to the calcium needs of pregnancy may obviate the need for increased intake has been ignored.

Parathyroid hormone production increases during the third trimester of pregnancy and has led some observers to believe that there is a state of physiologic hyperparathyroidism during pregnancy.[6] Of equal significance is the fact that the serum concentration of 1,25-dihydroxyvitamin D (1,25-$[OH]_2$D) is increased throughout pregnancy.[7,8] 1,25-$(OH)_2$D is the most active metabolite of vitamin D, and its synthesis requires the presence of parathyroid hormone. 1,25-$(OH)_2$D stimulates the absorption of calcium from the intestine. Calcium absorption is increased during the second trimester of pregnancy,[9] coinciding with the increase in 1,25-$(OH)_2$D. Furthermore, it has been demonstrated that pregnant women on diets not supplemented with calcium have decreased urinary calcium excretion compared to the nonpregnant state.[4] This decreased renal excretion of calcium may be due in part to the elevation of parathyroid hormone. Thus, pregnant women have the ability to both increase the intestinal absorption of calcium as well as decrease renal calcium excretion so as to maintain calcium homeostasis.

Is there evidence to suggest that the infant may be adversely affected by a maternal intake of calcium equivalent to the RDA of the nonpregnant state? In swine the variability in maternal dietary intake of calcium has no effect on the skeletal development of the offspring.[10] Likewise, postmortem studies on the mineral content of human fetal tibias of mothers of known nutritional histories demonstrated that the calcification of the fetal tibia is not affected by large differences in maternal calcium intake.[11]

Could an intake of calcium equivalent to the RDA be harmful during pregnancy? This is very unlikely, although there was earlier speculation that calcium phosphate supplements were associated with a fall in serum ionized calcium *and* resulting in leg cramps.[12] This potential complication is now avoided as calcium is given as a gluconate or carbonate complex without phosphorus.

SUMMARY. There is no evidence that increased calcium requirements above the nonpregnant dietary intake are needed during pregnancy. Exceptions to this may be the adolescent or woman with twins. There are maternal adaptations to the increased needs for calcium during pregnancy that result in increased intestinal absorption and decreased renal excretion of calcium. These physiologic adjustments are related in part to the increased serum 1,25-$(OH)_2$D and parathyroid hormone during pregnancy.

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WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

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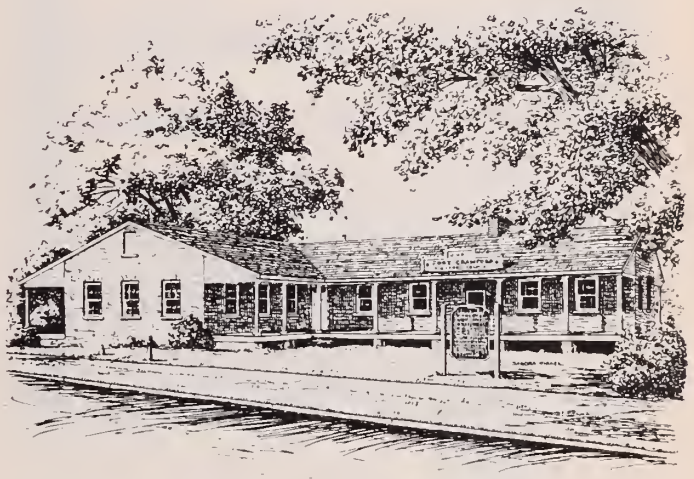
New SMS-sponsored health insurance plan for members and employees announced

A $1,000,000 catastrophic major medical (health insurance) plan went into effect April 1, 1982 for over 500 SMS members, their families, and their employees. The new carrier is Central Life Assurance Company, Wisconsin Life Division, Madison. The primary reasons for the change in plans are:

• The State Medical Society's House of Delegates adopted a resolution to encourage ". . .the concept of significant deductible and co-insurance options in health policies as a cost containment mechanism. . ." Therefore, it was felt the Society's endorsed plan for its members should follow this concept.

• The previous carrier, Blue Cross-Blue Shield United of Wisconsin, required a 47.8% rate increase to renew its coverage. This prompted SMS Services, Inc to seek competitive bids from other carriers. Central Life offered the most flexible plan and most competitive rate.

• There is a significant annual premium savings for the entire group by changing to the new carrier and plan. The annual premium bids on the new program ranged from the low of $667,000 per year from Central Life, $785,000 from a second bidder, to $996,000 from Blue Cross-Blue Shield. Blue Cross-Blue Shield required a premium of $1,226,000 for continuation of its present plan. By accepting the Central Life bid each subscriber will save approximately $1,100 per year in premiums before considering the deductible and co-pay features which are present in all plans, including the present one. ■



Update on jail health

Since 1976, the State Medical Society has been operating a program in conjunction with the American Medical Association to improve health care in Wisconsin jails. Since that time, the Society's jail health effort has been successful in accrediting nine jails as meeting the standards for health care in jails established by the program. With the termination last year of financial assistance from the US Department of Justice, the Society has found it necessary to redirect its effort to maximize limited resources.

The 1982 program will get underway on June 17-18 with a statewide conference on jail medical and health care for Wisconsin sheriffs, jail administrators, and nurses working in jails, sponsored by the University of Wisconsin-Extension, Department of Governmental Affairs, in cooperation with the State Medical Society of Wisconsin.

The conference, to be held on the campus of the University of Wisconsin-Oshkosh, will provide an opportunity for jail and health personnel to learn more on how to recognize and deal with health and medical problems of inmates, as well as how to establish an effective health and medical care system in a jail.

SMS will continue in 1982 to encourage the accreditation of Wisconsin jails which are willing to give the time and money to the effort. ■

1982 Season at Museum

Escape for a mini-vacation to a special place! The Charitable, Educational and Scientific Foundation's Fort Crawford Medical Museum is a unique facility set in the beautiful Mississippi River Valley at Prairie du Chien.

The museum complex opened its doors May 1 for the 1982 season. Hours are 10 AM to 5 PM daily through October 31. Guides are available to conduct tours and answer questions.

The restored second Fort Crawford Military Hospital is filled with relics of 19th Century medicine in Wisconsin. Visit an old-time drugstore, dentist office and physician's office, and step into a cell with a picture window.

Medical art and a gift shop are featured in the museum's administration building.

The "new" Hall of Fame pays tribute to Wisconsin physicians. See a replica of Doctor Frank Epley's office in New Richmond, the first MD in the Midwest to do blood transfusions.

Exhibits in the Hall of Health are aimed to help visitors assume more responsibility for better health. Several new exhibits have been added this year on subjects such as emergency medical identification, home poisonings, quackery, drugs, and health appraisal.

The Fort Crawford Medical Museum is located at 717 South Beaumont Road in Prairie du Chien. Free admission is extended to physicians. ■

MEMBERSHIP UPDATE

The following physicians, by county medical society, have recently been elected to membership, or have been reelected or reinstated since publication of the Membership Directory in the January issue of the *Wisconsin Medical Journal,* with the specialty abbreviated above the name:

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New round of Medicaid audits begins

The Dept of Health and Social Services (DHSS) has begun the second round of post-payment audits of Medical Assistance providers. Twenty-five physician sites are involved. They were carefully selected from indications for audit developed from patterns of practice and billing revealed by the Department's management information system (EDS).

The SMS has agreed with the Department on the necessity for audits in situations of alleged questionable patterns of practice or billing. A committee of SMS met with DHSS and representatives of JL Trainor, Inc, a management consulting firm which has the contract to engage Wisconsin CPAs to conduct the audits. The committee urges physicians to be aware of certain information which it hopes will minimize problems associated with what the Department perceives to be necessary audits:

1. The medical site (individual physician or clinic) selected for audit will be contacted about two weeks in advance of the anticipated audit date. The auditor is to telephone for a specific appointment. The physician may negotiate the exact time of that appointment.
2. The auditor will present the doctor with a request for specific Medicaid patient files for review. The auditor will also have a vendor request form which identifies all payments made to the physician during the audit period for the individual recipients for whom records are being requested.
3. In an initial interview with the physician, general Medicaid information will be discussed. The auditor will ask for, and should be provided, a reasonably appropriate place to work. Physicians have a right to be personally present or have a representative present during the entire period for purposes of protection of records. The physician has no right to harass or abuse the auditor.
4. Auditors will not seek access to private-pay medical records (patient care records). However, the physician must, if requested, provide some acceptable evidence that T-19 patients are not being charged more than private-pay patients for the same type of service. A notarized statement from a physician may suffice in some instances.
5. Audits may involve a request to look at hospital and nursing home records. The physician may request the opportunity to personally obtain those records, or copies thereof, from the hospital and bring them to the doctor's office rather than having the auditor go to either the hospital or nursing home.
6. The usual audit takes from six to eight working days. An exit interview with the physician will be provided by the auditor to explain his/her findings and to reveal a so-called "discrepancy list" in the event there are differences between the Department's records and the doctor's records, or there appear to be other matters of concern to the auditor. At this point, no final dollar amounts are available.
7. J L Trainor, Inc will review the initial findings of the audit; then the Bureau of Health Care Financing in DHSS will review.
8. The Bureau will then send a "draft report" to the physician for review. The doctor may dispute it in full, or in part, request corrections, or ask for a re-audit of the disputed issue.
9. When the report becomes "final" the physician will be informed and given an opportunity to request a formal administrative hearing pursuant to the statute.

Physicians should be aware that the first audit series of 25 selected physicians resulted in recovery of almost $700,000 with amounts ranging from $1,000 to $170,000 in individual cases.

The principal reasons for recovery of "overpayment" amounts were inflated office visit codes (charging for an extensive office visit when the doctor's record justified only a routine visit, for example); billing for OB care by trimester rather than total care, or billing surgical services in segments rather than pre- and postoperative care as part of the surgery; missing service records, duplicate billing, no patient record to back up the claim for Medicaid payment, and in some instances, overpayment by EDS resulting from processing error.

Physicians who have questions concerning this information, or specific audits being undertaken through J L Trainor, Inc should call SMS headquarters. ■

NEWS YOU CAN USE

LAKE WINNEBAGO HEALTH SYSTEMS AGENCY CLOSES DOORS. On a narrow vote, the Board of Directors of the Lake Winnebago Area Health Systems Agency (LWAHSA) in March voted to close. In taking the action the Board cited that federal funding cutbacks made it impossible to meet federal program requirements at existing staff levels. Effective March 25, 1982, the State Bureau of Planning and Development assumed sole responsibility for certificate-of-need in the Lake Winnebago area. Providers should address any inquiries relating to certificate-of-need matters directly to the Bureau of Planning and Development, PO Box 1808, Madison, Wisconsin 53701-1808. ■

Child restraint bill passes, Legislature adjourns

The Wisconsin Legislature managed to pass a child seat restraint bill but killed a "watered down" smoking regulation bill before concluding its 1981-82 legislative session in April. Legislators had to stay in town, however, to meet in extended session to work on legislative reapportionment and the budget adjustment bill. Any bills that didn't receive final approval from both houses by April 2 are now dead for this session. Here's a brief rundown of the action:

• **Child seat restraints—AB 600:** Passed the Senate and Assembly on a voice vote April 2 and now awaits the Governor's signature. The bill, as amended, requires children under age two to be properly restrained in a federally approved child safety restraint system while being transported by their resident parents. The bill calls for a fine of between $30 and $75. *SMS supported.*

• **Smoking regulation—SB 80:** Died in the Senate after that body failed to act on Assembly amendments. The original bill was intended to restrict smoking to designated areas in public settings such as restaurants, waiting rooms, government buildings, and public conveyances by posting signs. The Assembly's amended version would have allowed entire buildings to be designated as smoking areas and eliminated the no smoking areas in restaurants that hold liquor licenses. *SMS supported.*

• **Mumps immunization—SB 578:** Passed the Assembly on a 93-3 vote and now is before the Governor. The bill adds mumps to the state's immunization checkpoint law. Children must now be immunized or be on an immunization schedule prior to admittance to school—K through 12 for measles, rubella, diphtheria, pertussis, polio, and tetanus protection. Exemptions to the requirement are allowed for medical, religious or personal conviction reasons. *SMS supported.*

• **Informed consent—AB 941:** Passed both houses and now awaits the Governor's signature. The bill makes statutory the 1975 Wisconsin Supreme Court decision in *Scaria v St Paul Marine and Fire Insurance Company* which requires any physician who treats a patient to inform the patient about the availability of all alternate, viable medical modes of treatment and about the risks and benefits of these treatments. Failure to disclose the proper information would result in a charge of unprofessional conduct.

• **Malpractice—AB 537 & SB 628:** Died in Assembly Insurance Committee after passing the Senate as a combined substitute amendment to SB 628. The original bills made a variety of changes in the Patients Compensation Panels and some technical changes to WHCLIP and the Patients Compensation Fund. The substitute amendment would have increased the number of formal panels from four to six (AB 537 provided for as many panels as necessary to handle the caseload); eliminated a provision in AB 537 to allow parties in a panel action to challenge the appointment of panel members, and prohibited WHCLIP from refunding overcharges to policyholders. *SMS supported* the original bills: AB 537 and SB 628. ■

Physician supply committee begins work

The DHSS Physician Supply and Recruitment Study Committee held its first meeting in late March.

The Committee was directed in the 1981-83 bienniel budget bill to report to the Legislature by October 1, 1982 on the type and number of physicians by specialty necessary to meet state needs and projections by the year 2000.

Kermit Newcomer, MD, La Crosse, member of the SMS Health Planning Commission represents the Society on the committee.

Other members appointed by DHSS Secretary Donald Percy are: Chairman-Frank Kosednar, Northwestern Mutual Life Insurance Co; Yves Balcer, assistant professor of economics, UW-Madison; Donald Fullerton, MD, UW Medical School; Paul Rosenfeld, MD, Medical College of Wisconsin; Robert Green, MD, La Crosse, Medical Education Review Committee (MERC); Wayman Parker, MD, Milwaukee; Donald Fundingsland, president, Waukesha Hospital; Earl Strub, administrator, Cumberland Memorial Hospital, and Shari Kaplan, Milwaukee. ■

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Study requested on public health system

The Legislative Council would have been directed to study the existing public health and health planning systems at both state and local levels, under a Joint Resolution introduced in the Assembly in late March by State Rep John Robinson (D-Wausau) and State Sen Paul Offner (D-La Crosse).

The resolution, which was introduced at the request of the State Medical Society of Wisconsin, is part of an effort to renew the State's commitment to public health in the face of declining federal support. Unfortunately, the Legislature adjourned in April before it was able to act on the measure. A similar bill will be introduced in the 1983-84 session.

"Wisconsin needs a full-service public health system," the resolution reads. "Community health services, environmental health services and mental health services are essential components of such a system and integrating these services requires administration by one unit of state government."

The resolution called for consolidating all public health services in the Division of Health in the Department of Health and Social Services.

"Such a consolidation will ensure that the highest quality public health services are available throughout the state in the most efficient and economical manner possible, while making it possible to upgrade and standardize the direct provision of public health services at the local level," according to resolution sponsors Robinson and Offner. The legislators are also worried about the absence of policy direction regarding the future of the now federally funded Health Planning program. "When Washington eliminates its support, the state is going to have to decide whether or not it wants to continue financing the seven area Health Systems Agencies," Robinson said. "Furthermore, we've got to review current regulatory functions and determine what type of locally-based, voluntary system may be warranted as an alternative." Senator Offner expressed concern over the failure of government to prepare adequately for changing responsibilities in the delivery of health services. Offner's interest stems, in part, from his past involvement as assistant director of the Western Wisconsin Health Systems Agency. Rep Robinson is a member of the Assembly Health and Human Services Committee.

The Joint Resolution would direct the Legislative Council to submit its conclusions to the Legislature by January 1, 1983. The Council will have several resource documents on which to draw, including recent reports by both the State Medical Society's Commission on Health Planning and the statewide Health Coordinating Council. ■

SMS involved in healthcare discussions with WEA

Healthcare cost discussions are underway between the State Medical Society and the Wisconsin Education Association Council and its Insurance Trust. Left to right above are Albert J Motzel Jr, MD, Waukesha, SMS president; Peter Magnoni, WEA Trust cost containment administrator; Carmen Stout, Westby, WEA Council president; Morris Andrews, Madison, WEA Council executive director; and Russell F Lewis, MD, Marshfield, SMS past president. Also present at this meeting, but out of range of the camera, was Bernard Weidenaar, WEA Trust executive. The discussions seek methods to contain medical and healthcare costs for teachers insured through the WEA Insurance Trust. (Staff photo by Diane Upton)

ANNUAL PERCENTAGE INCREASES IN SELECTED COMPONENTS OF THE CONSUMER PRICE INDEX

	Selected Items								
	All Items	All Services	Food and Beverages	Housing	Medical Care	Prescription Drugs	Physicians' Services	Dental Services	Hospital Room Charges
Average Annual Percentage Increase 1972-1981	8.6	9.4	8.4	9.3	9.1	5.9	9.0	7.7	12.0
1980	12.4	14.2	10.1	13.7	10.0	9.8	11.0	10.7	13.9
1981	8.9	13.0	4.3	10.2	12.5	12.6	11.7	10.2	17.0

SMS 1983 proposed dues increase tied to CPI

The SMS House of Delegates will act during its 1982 session, May 13-15, on a proposal to increase SMS dues in 1983 by 4.9%. The proposed increase is in accordance with a 1978 House action which stated "that dues be adjusted annually to recognize the effects of inflation on the Society's budget, so that annual dues be structured to reflect, but not exceed the annual CPI rate" (all items portion). See chart above. ■

AMA Foundation awards grants to Wisconsin medical schools

Of the total of $1.5 million channeled to the nation's medical schools in grants from the American Medical Association Education and Research Foundation, Wisconsin's two medical schools received a combined total of $27,228.31. The University of Wisconsin Medical School, Madison, received $12,491.82 while the Medical College of Wisconsin, Milwaukee, received $14,736.49.

"Members of the AMA Auxiliary once again have worked unstintingly to raise funds for the medical school grant program," notes George H Mills, MD, a Honolulu physician and Foundation president. The Auxiliary units throughout the country consistently have taken the lead in bringing in substantial funds for the projects of the AMA's Education and Research Foundation, according to Doctor Mills. More than $36 million has been raised by AMA-ERF for medical schools over the years.

Much of the money earmarked for grants to specific schools comes from physicians who are graduates of those schools and who wish to support their alma mater.

Grants are made directly to the deans of the schools in the form of unrestricted funds to help them pursue excellence in the medical school programs. ■

Medical Retirement Seminar

The American Association of Senior Physicians (AASP) is a not-for-profit national association devoted exclusively to serving the needs of senior physicians.

The AASP will be conducting five retirement seminars during the year (dates and locations listed below), and is extending invitations to all physicians age 55 years and over to attend. These two-day seminars are designed to better acquaint physicians with the mechanics of closing a practice. In addition, they emphasize the psychological and financial advantages that can accrue when proper thought and planning are effectively used to develop "your" retirement—or practice modification—strategy.

Utilizing the four cornerstones of a successful medical retirement, the seminar agenda has been divided into the following areas of concentration: Assessment, Planning, Implementation, and Monitoring. Topics to be discussed include, but are not limited to: How to determine when it is time to retire, the personal side of retirement, medical licensure requirements, CME, insurance, inflation in retirement, second careers, selling or transferring your practice, closing your practice, and effective estate planning.

Seminar costs are $150 for AASP members; $175 for non-members. Spouses are urged to attend at no additional cost. Early registration is recommended as seminars will be limited to 60 people, including spouses.

1982 DATES AND LOCATIONS: Chicago, April 23-24; New Orleans, May 28-29; Philadelphia, July 9-10; Denver, August 29-30; Annual AASP Meeting and Seminar (to be announced).

To receive a copy of the seminar agenda and details on accommodations, contact: American Association of Senior Physicians, 536 North State St, Chicago, Ill 60610; or phone 312/644-3092. ■

Obituaries

Harold J Dvorak, MD, 79, Milwaukee died in November 1981 in Milwaukee. Born Mar 28, 1902 in Milwaukee, Doctor Dvorak graduated from the University of Pennsylvania Medical School in 1925 and served his internship at University Hospitals (formerly Wisconsin General Hospital) in Madison. His residency was completed at the University of Minnesota Hospital where he also did postgraduate work at the Mayo Clinic in Rochester, Minn. He was a co-founder of Family Hospital (formerly Doctors Hospital) in Milwaukee. He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association. Surviving are his children, Harold F Dvorak, MD and Ruth D Stringfield, RN.

Reynold Anthony Nocella, MD, 52, Wauwatosa, died Jan 14, 1982 in Wauwatosa. Born June 13, 1929 in New York, Doctor Nocella graduated from Georgetown University School of Medicine, Washington DC, in 1956. He served his internship at Georgetown University Hospital and completed his residencies in psychiatry at Georgetown University, the Mental Health Institute in Independence, Ia, and Northwestern University in Chicago, Ill. Doctor Nocella served in the United States Air Force from 1958-1960. He was a member of the medical staff of Milwaukee Psychiatric Hospital in Wauwatosa. He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and the American Medical Association. Surviving are his widow, Eleanor; and two children, Frederic and Susan.

George Henry Lane, MD, 79, Milwaukee, died Jan 26, 1982 in Milwaukee. Born July 2, 1902 in Jonestown, Miss, Doctor Lane graduated from Meharry Medical College in Nashville, Tenn, in 1931, and completed his internship at Hubbard Hospital in Nashville. He practiced in Greenwood, Miss, until 1956 when he moved to Milwaukee. In the late 1960s, Deaconess Hospital, now part of the Good Samaritan Medical Center, began a program of screening for sickle cell anemia of which Doctor Lane was appointed its full-time director. He retired from medicine in 1972. A member of The Medical Society of Milwaukee County, he received the "Distinguished Service Award" in 1980. He also was a member of the State Medical Society of Wisconsin, the American Medical Association, the Cream City Medical Society, and the National Medical Association. Surviving is his widow, Laura of Milwaukee.

Ralph Charles Frank, MD, 66, Eau Claire, died Feb 3, 1982 in Eau Claire. Born Oct 28, 1915 in Milwaukee, Doctor Frank graduated from Harvard Medical School in 1943 and served his internship at the United States Naval Hospital in Great Lakes, Ill. His residency was completed at the University of Wisconsin Medical School in Madison. He had practiced in Eau Claire from 1949 until 1982. Doctor Frank was a councilor of the State Medical Society of Wisconsin from 1959 to 1965 and served on its Committee on Cancer for many years. He was a member of the Wisconsin Division, American Cancer Society and served as its president in 1960. In 1962 he received the "Distinguished Service Award" from the American Cancer Society. Doctor Frank was chief of radiology at Sacred Heart Hospital, Eau Claire, and also served as president of the State Council on Health. He was a member of the Wisconsin Radiological Society; Radiological Society of North America; American College of Radiology, and American Roentgen Ray Society. He was a member of the Eau Claire-Dunn-Pepin County Medical Society, and the American Medical Association. Surviving are his widow, Ruth; one daughter, Kay Rocco, Eureka, Calif; two sons R William and Peter, Eau Claire; four grandchildren; and one sister, Mrs Edward Augustine of Baileys Harbor.

Clement Allen Meilicke, MD, 80, a former Oshkosh physician, died Feb 4, 1982 in Sheboygan. Born Aug 3, 1901 in Hector, Minn, Doctor Meilicke graduated from Marquette University School of Medicine in 1926. Doctor Meilicke practiced medicine in Oshkosh for 35 years, retiring in 1961. For the past 20 years he had been living in Crystal Lake. He was a member of the Winnebago County Medical Society, State Medical Society of Wisconsin, and the American Medical Association. Surviving are his widow, Helen; one daughter, Eugenia Clark, Stuart, Fla, and one son, Melvin of Sheboygan.

George Hobert Ewell, MD, 84, Madison, died Feb 27, 1982 in Madison. Born Aug 18, 1897 in Bogard, Mo, Doctor Ewell graduated from St Louis University School of Medicine in 1920 and served his internship at St Joseph's Hospital, Kansas City, Mo. His residency was completed at Lennox Hill Hospital, New York and at University Hospital in Philadelphia, Pa. In 1927 he became a member of the medical staff of the Jackson Clinic and practiced in the Department of Urology until his retirement. He was a member of the Editorial Board of the *Wisconsin Medical Journal* in the 1930s and also was acting Medical Editor. Doctor Ewell was a member of the American College of Surgeons, American Urological Association, International College of Surgeons, in which he served as a regent, and the American Medical Association. He had served as president of the Dane County Medical Society in 1951-52, and in 1970 he became a member of the "50 Year Club" of the State Medical Society of Wisconsin. Surviving are his widow, Hilda; a daughter Patricia Ewell Trumble of Boulder, Colo; four grandchildren, and one great grandchild.

Albert Charles Schmidt, MD, 80, Milwaukee, died Mar 7, 1982 in Milwaukee. Born Feb 28, 1902 in Eustis, Neb, Doctor Schmidt graduated from the University of Nebraska College of Medicine in 1930 and served his internship at Columbia Hospital in Milwaukee. His residency was completed at the old Johnston Emergency Hospital in Milwaukee, University Hospitals at the University of Oklahoma, and the Hospital for Ruptured and

Crippled in New York. Doctor Schmidt was the former chairman of surgery of the Department of Orthopaedics at Milwaukee Children's Hospital and chairman of orthopaedics at Columbia Hospital. He also was a clinical professor of orthopaedic surgery at The Medical College of Wisconsin. Doctor Schmidt co-designed the Milwaukee Brace with Dr Walter Blount. In 1970 he was honored by the Milwaukee orthopaedic Residents Alumni Club and in 1979 he became a member of the "50 Year Club" of the State Medical Society of Wisconsin. He also was a member of the American Academy of Orthopaedic Surgeons, American Orthopaedic Association, Clinical Orthopaedic Society, New England Orthopaedic Society, The International Society of Orthopaedic Surgery and Traumatology, the German Orthopaedic Society, The Scoliosis Research Society, Wisconsin Orthopaedic Society, Chicago Orthopaedic Society, Milwaukee Surgical Society, The Medical Society of Milwaukee County, and the American Medical Association. Surviving are his widow, Margaret; and two sons, Albert C Jr, Glen Ellyn, Ill, and Robert of Milwaukee.

Nels Philip Anderson, MD, 90, La Crosse, died Mar 8, 1982 in La Crosse. Born Aug 9, 1891 in St Paul, Minn, Doctor Anderson graduated from the University of Minnesota Medical School in 1914 and served his internship at University Hospitals in Minneapolis. He served in the United States Army Medical Corps during World War I. Doctor Anderson was associated with the Grandview Hospital in La Crosse for many years and had also served as its chief-of-staff. He was a member of the "50 Year Club" of the State Medical Society of Wisconsin, a member of the La Crosse County Medical Society, and the American Medical Association. Surviving are his widow, Evelyn; two sons, Patrick, La Crosse, and Dr Paul, Phoenix, Ariz; and two daughters, Mrs William (Priscilla) Dvorak, La Crosse, and Mrs John (Petra) Beatty of West Hartford, Conn.

Ervin L Bernhart, MD, 82, Milwaukee, died Mar 11, 1982 in West Allis. Born Aug 25, 1899 in Milwaukee, Doctor Bernhart graduated from the Marquette University School of Medicine in 1925. His internship was completed at St Mary's Hospital, Milwaukee. Doctor Bernhart specialized in industrial medicine and had been the chief-of-staff and executive board member of St Mary's Hospital, Milwaukee, and the president of the Midwest Medical Association. He served as president of the State Medical Society of Wisconsin, 1955-1956; and was president of the Wisconsin Academy of Family Physicians. He was a delegate to the American Medical Association, 1959-1971; councilor to the State Medical Society, 1951-1959; and was a president of the Charitable, Educational and Scientific Foundation of the State Medical Society. He served as president of the Medical Society of Milwaukee County and on many committees of his county society, including the Surgical Care-Blue Shield Committee, of which he was chairman. He also was a Wisconsin delegate to the American Academy of Family Physicians, 1949-1953; commissioner on Industrial Health of the AMA; member of the State Society's Commission on Prepaid Plans, and had served as president of the Wisconsin Medical Golf Association. Doctor Bernhart had been a member of the American Cancer Society, American Heart Association, and had been the medical director of the Milwaukee Transport Company. He also was a member of the World Medical Association and the Milwaukee Academy of Medicine. He became a member of the "50 Year Club" of the State Medical Society of Wisconsin in 1975. Surviving are his widow, Edith; two sons, John, Mahwah, NJ, and David, Denver, CO; and two daughters, Mrs Edith (John) Bergs, Milwaukee, and Mrs. Susan (Conrad) Langenberger of Brookfield. ■

National Child Abuse Prevention Week—June 6-12, 1982

The week of June 6 through 12, 1982 has been designated as National Child Abuse Prevention Week by joint resolution of the US Senate and House of Representatives. The Bureau for Children, Youth and Families, Parents Anonymous of Wisconsin, the Wisconsin Chapter for the Prevention of Child Abuse and Neglect, the Division of Community Services' Education-Information Section, and the Governor's office are coordinating their efforts as part of a statewide public information campaign for Wisconsin. The theme of the campaign is "It shouldn't hurt to be a child—but often it does."

Goals for the week will be to:

. . .make the public aware of the incidence, origins, and effects of child abuse and neglect.

. . .emphasize that reporting suspected child abuse is not "meddling" but is being concerned. It is everyone's responsibility to report—to protect children and to get help for troubled families.

. . .inform people about programs and efforts to prevent child abuse and assist families in which child abuse occurs.

. . .encourage people to reach out to families that are isolated or under stress.

. . .encourage communities to expand programs and efforts to prevent child abuse: parent education, hot lines, self-help groups, crisis child care, counseling and family therapy.

The Division of Community Services will be providing information sheets, a flyer, and Wisconsin's Child Abuse and Neglect Prevention Week Proclamation to other agencies, organizations, and groups.

Physicians are encouraged to participate in this effort and may receive further information by contacting Susan Notkin, Chief, Special Needs Section, Bureau for Children, Youth and Families, Room 570, PO Box 7851, Madison, Wis 53707; phone 608/267-7732; or Connie Krolick, Public Information Specialist, Education-Information Section, Room 561, PO Box 7851, Madison, Wis 53707; phone 608/266-5590. ■

RACINE

MDs and Labor develop healthy alliance

The following article is being reprinted with permission from Lynn and Jan Griffin who wrote it for *The Racine Labor,* appearing in the March 26, 1982 issue:

* * *

A rather unique situation exists in Racine. Representatives of the Racine County Alliance for Labor and the Racine County Medical Society have been meeting periodically for the last five to six years to discuss common problems.

Some of the issues which have been discussed to date include the patient/physician relationship, billing practices, problems involving insurance carriers, HMOs, worker's compensation, physician policy regarding new patients and second opinions to name a few.

These meetings have been beneficial to both labor and the medical community. They have opened a line of communication so that differences can be worked out before major problems occur.

The patient/physician relationship is something that affects all of us. It is important to have confidence in one's physician—your life might depend on it. Therefore, when the patient feels he would like a second opinion or is unhappy with his doctor, he should talk to his doctor about the situation.

One's own physician is usually the best source of a competent second opinion. Physicians do care about their patients and would like to know if their relationship has been damaged. If you do decide to change doctors, let your prior physician know.

The back to work slip, an understanding of the pregnancy policy and promotion of the phone number (634-0702) patients can call to get a doctor have resulted from these meetings. Work is continuing on obtaining guidelines for orthopedic cases so that a more uniform situation will exist.

Physicians are becoming more aware of what conditions exist in the shops in town—*ie,* types of work available, working conditions, etc and labor is becoming more aware of the problems physicians face—*ie,* paperwork requirements for worker's compensation, insurance benefits, etc.

All in all, we are all finding out that we are not alone. Labor has problems and so do the doctors. However, it is apparent that by working together we may be able to resolve many of the situations for the good of all.

Only because doctors and labor do care about the people of Racine are these meetings meaningful to all.

LINCOLN: The Lincoln County Medical Society recently reelected Geoffrey C Kolster, MD,* Merrill, as president for the year 1982-83. Other MDs elected to office are M Yusof Ahmad,* vice president; Donald L Evans,* secretary; James S Janowiak, MD,* delegate, and Jerome S Mayersak,* as alternate delegate. All the physicians are from Merrill.

WINNEBAGO: Fifty members and two guests were present at the April meeting of the Winnebago County Medical Society to hear Dr Kenneth Printen, University of Iowa, present a paper on "Fat: Myth or Magic."

WOOD: The Wood County Medical Society, at its March 19 meeting held in Marshfield, presented the Presidential Life Membership to Russell F Lewis, MD,* immediate past president of the State Medical Society of Wisconsin. The guest speakers were Russ Bradey, Washington, DC, and Ron Hendricks who is the Fifth District field consultant of the SMS Physicians Alliance. Mr Bradey spoke on the effectiveness and functioning of AMPAC and WISPAC. Twenty members were present to propose the following resolution for presentation to the House of Delegates at the SMS Annual Meeting in May: "Be it resolved that the State Medical Society urge improved State Funding of Public Health Sanitation Services and some similar public health activities." The resolution passed. ■

NEWS YOU CAN USE

COUNTY SOCIETIES LAUNCH PUBLIC ASSISTANCE PROGRAMS. Two medical societies have announced programs to assist patients who have trouble paying for physicians' services. The King County Medical Society (Washington) last month launched a program that matches requests for medical care with some 1,000 physicians who have agreed to see patients with little or no money. The program grew out of a four-county survey on the availability of medical care conducted by the Washington State Medical Association in anticipation of the possible closing of a US Public Health Service Hospital. ¶The Arlington County Medical Society (Virginia) approved a plan to provide free physicians' services to residents who lose their Medicare-Medicaid benefits through federal budget cuts. The society will assess the needs of affected individuals and assign the patients to primary care physicians. Those who need specialized care will be referred to participating specialists. ■

Physician Briefs

* Physician members of State Medical Society of Wisconsin

James W Hoftiezer, MD,* Manitowoc, recently became Board certified by the American Board of Internal Medicine. An internist and gastroenterologist with the Lakeshore Internal Medicine in Manitowoc, Doctor Hoftiezer graduated from the University of Illinois School of Medicine, Chicago, and completed his residency and fellowship at the University of Missouri, Columbia.

Richard E Silberman, MD, Milwaukee, was the featured speaker at the Community Health Series of St Luke's Hospital. Doctor Silberman, a cardiologist on the medical staff of St Luke's, spoke on "Jogging: Start to Finish." The series is sponsored by St Luke's Hospital Foundation.

Willard G Huibregtse, MD,* Sheboygan family practitioner from 1934 until his retirement in 1981, recently was named "Outstanding Alumnus of the Year" at the annual Founders' Day Dinner of the Sheboygan County University of Wisconsin Alumni Club. He was cited for his many contributions to the community. Doctor Huibregtse graduated from the University of Wisconsin Medical School in 1933 and after serving his internship in Chicago, he started his medical practice in Sheboygan. In 1962 he served as president of the Sheboygan County Medical Society, and in 1969 Doctor Huibregtse served a two-month volunteer duty in Vietnam.

J Robert Grove, MD, La Crosse, recently was certified as a diplomate in the specialty of Cardiovascular Diseases. A member of the Skemp-Grandview-La Crosse Clinic and the medical staff of La Crosse Lutheran Hospital, Doctor Grove also is medical director of the Coronary Intensive Care Unit of Saint Francis Medical Center. He recently co-authored scientific articles in the *Wisconsin Medical Journal, Circulation,* and *Archives of Internal Medicine.*

Robert T Obma, MD,* La Crosse, recently was certified as a diplomate in the specialty of Cardiovascular Diseases. A member of the Skemp-Grandview-La Crosse Clinic, Doctor Obma is associate medical director of the La Crosse Cardiac Rehabilitation Program sponsored by the University of Wisconsin-La Crosse. He is on the medical staff at Saint Francis Medical Center and La Crosse Lutheran Hospital and also serves as the team physician for the United States Ski Team. He served as a consultant to Central Michigan University for the purpose of evaluating a cardiac rehabilitation program and recently edited a book entitled *Ski Jumping: Results of Physical Testing and Technique Studies.*

Claude W Schmidt, MD,* Waukesha, recently was honored by the American College of Obstetricians and Gynecologists for his three weeks of service with the US Public Health Service's Indian Health Service. The volunteer program, operating since 1974, gives physicians on the staff of the Indian Health Service time off for seminars, training, and vacations. Doctor Schmidt is affiliated with the medical staff of Waukesha Memorial Hospital.

Mark A Sager, MD,* Manitowoc, recently was appointed medical director of St Mary's Home for the Aged. Doctor Sager, who is affiliated with the Manitowoc Clinic, graduated from the University of Michigan Medical School, Ann Arbor, and completed his internship and residency at the University of Minnesota Hospital in Minneapolis.

Martin L Rimestad, MD, Des Moines, Ia, will be joining the medical practice of Orrin N Arneson, MD,* Amery, in July. Doctor Rimestad graduated from the University of North Dakota School of Medicine and is currently finishing his residency at Broadtown Medical Center, a University of Iowa affiliate in Des Moines. Doctor Rimestad also has had emergency medicine experience at Mercy Medical Center, Northwest Community Hospital, Madison County Hospital, and Grinnell General Hospital, all in Iowa.

Arlene M Brown, MD, second-year resident in the Good Samaritan Medical Center/Medical College of Wisconsin Family Practice Residency Program, recently was granted a Mead Johnson Award for Graduate Education in Family Practice. Doctor Brown, a medical school graduate of the University of New Mexico and a native of Los Alamos, NM, will receive $1500 during her third year of residency at Good Samaritan. She also will be provided with complimentary transportation to the American Academy of Family Physicians' annual conference in San Francisco later this year.

Charles D Brummit, MD,* Oconomowoc, recently returned from a meeting sponsored by Syntex Research at its home office in Palo Alto, Calif. Doctor Brummit was one of 20 physicians nationwide invited to attend the meeting prior to the start of a drug research program that is being coordinated by the Institute for Biological Research and Development, Inc. Wilkinson Clinic, SC, of which Doctor Brummit is a member, has been affiliated with the Institute since March 1981 and has participated in numerous research programs monitored by the Institute for the pharmaceutical companies, in compliance with FDA regulations.

Timothy J Devitt, MD,* Soldiers Grove, has been recertified as a diplomate of the American Board of Family Practice (ABFP).

Roy Clifton Selby Jr, MD, LaCrosse, has joined the medical staff of St Francis Medical Center in the Department of Neurosurgery. Doctor Selby most recently was neurosurgical consultant at Rush Presbyterian-St Luke's Medical Center, Chicago, and also has been head of neurosurgery at General Hospital, Kuala Lampur, Malaysia; and chairman of neurosurgery at Cook County Hospital, Ill. He has been a professor at Cook County Post Graduate School of Medicine since 1970, and a visiting associate professor of neurosurgery at Rush Presbyterian-St Luke's. Doctor Selby graduated from the University of Arkansas School of Medicine.

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Joel B Hellman, MD, Dodgeville, recently became associated with the Dodgeville Clinic. Born in New York, Doctor Hellman graduated from the University of Illinois College of Medicine, Chicago, and completed his residency at the Medical College of Wisconsin, Milwaukee, and at West Suburban Hospital, Oak Park, Ill.

Sin Choo, MD, recently joined Sik Q Jew, MD* in the Department of Neurology at the Monroe Clinic. Doctor Choo graduated from the University of Singapore School of Medicine and served his internship at Penang General Hospital in West Malaysia. His residency was completed at Lawrence General Hospital in Massachusetts and at Burlington County Memorial Hospital, Mt Holly, New Jersey. He also had training at the Neurological Training Program at the University of Ottawa, Ontario, Canada; Children's Hospital of Eastern Ontario; and he had a research fellowship in neurosurgery at the University of Ottawa.

Steven R Gambert, MD* recently was presented a Geriatric Medicine Academic Award by the National Institute of Aging. He is associate professor of medicine and physiology and chief of the section of geriatrics and gerontology at the Medical College of Wisconsin. Edward J Lennon, MD,* MCW dean said, "The $290,000 grant is a tribute to Doctor Gambert's accomplishments in the evolving field of gerontology." During the three years that Doctor Gambert has been at the Medical College of Wisconsin, he has organized an extensive program in geriatrics and gerontology to include a full continuum of care for the aging veteran at the Veterans Administration Medical Center, Wood, and a multidisciplinary consultation team at Milwaukee County Medical Complex. ■

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Lutheran Hospital Campus of Good Samaritan Medical Center, Milwaukee, recently named the following physicians to head its medical staff. They are MDs David J LaFond,* Elm Grove, chief-of-staff; William L Deardorff, Elm Grove, vice chief-of-staff; and Thomas J Flately,* Whitefish Bay, secretary. The new department heads are MDs Conrad M Heinzelmann,* Brookfield, surgery; William B Rabeen, Glendale, anesthesiology; Hanno H Mayer, Fox Point, medicine; Charles J Locher,* Shorewood, radiology, and Eric P Conradson,* Brookfield, has been elected a member-at-large.

The Fox Valley Family Practice Residency Center in Appleton recently held a reception for the people who were instrumental to the Center's existence. Two films produced by the American Academy of Family Physicians and titled "The Family Practice Residency in Your Community" and "To Your Future Health," were premiered. Charles E Fenlon, MD,* is director of the Center and was featured in the second film. The Center is a general medical clinic, open to the public, and provides health care services to the Fox Valley area. The Center has reported that it currently has 13 resident physicians on its staff and this number will expand to 19 in July.

St Mary's Hospital Medical Center, Green Bay, has been presented with the Wisconsin and American Hospital Association's Certificate of Recognition acknowledging its efforts to more effectively monitor costs and productivity. Through participating in a management information program provided by Hospital Administrative Services (HAS), through the Wisconsin Hospital Association, St Mary's has reported that it is able to compare costs and productivity both internally and with other facilities of comparable bed sizes. "Using the HAS program we are able to gauge our own effectiveness and keep costs down," the hospital's administrator Al Laabs stated. St Mary's has been using HAS programs since moving to their new facility last November, and regularly applies the information to cost containment efforts. They currently utilize "monitrend," designed to provide even more effective management data, Laabs noted.

Oconto Memorial Hospital's medical staff recently named Glen J Heinzel, MD,* Oconto, as chief-of-staff. The former chief-of-staff, John S Honish, MD,* Oconto, is vice chief-of-staff, and David P Losh, MD, Abrams, is secretary.

Wisconsin Medical Examining Board, Madison, has announced the confirmation of two Wisconsin physicians to its Board. The appointment of Susan F Behrens, MD,* Beloit, and the reappointment of Nelson A Moffatt, MD,* Marshfield, were confirmed by the Wisconsin Senate. ■

AMA Physician's Recognition Award Recipients

LISTED BELOW are those physicians in Wisconsin who have earned the AMA Physician's Recognition Award in recent months. The award was established in 1969 "to recognize, encourage and support physicians who participate regularly in continuing medical education and to emphasize the importance of developing more meaningful continuing medical education opportunities for physicians." A minimum of 150 credit hours of CME must be earned over a three-year period to qualify for the award. The hours may include such activities as conferences, residencies, teaching, writing, private reading, listening to cassettes, home study courses, consultation, and peer review; at least 60 of the hours, however, must be from formal CME programs sponsored or cosponsored by organizations accredited for these activities. The State Medical Society of Wisconsin congratulates the following physicians who have distinguished themselves and their profession by their commitment to continuing education:

MARCH 1982

*Betlach, Eugene H, Janesville
*Bigalow, James, Merrill
*Block, Margaret, Monroe
*Breadon, George E, Monroe
*Docktor, John P, Milwaukee
*Finch, David R, Appleton
*Gerol, A Yale, Kenosha
*Gueldner, Terry L, Manitowoc
*Hamacher, John E, Madison
*Hecht, Rudolph C, Madison
*Holt, Robert E, Milwaukee
*Jordon, Robert E, Wood
Kampschroer, Bernard H, Milwaukee
*Klemm, Frederick A, Wausau
Laird, Anna K, Madison
*Levy, Donald M, Milwaukee
*Lubing, Harold N, Madison
*Maloney, Patrick M, Marshfield
*Melvin, John L, Milwaukee
Offenkrantz, William C, Milwaukee
*Oujiri, John C, Ashland
*Ramos, Teodoro M, Ripon
*Regala, Emilio B, Hartford
*Saarinen, David M, Ashland
*Sable, Morris H, Milwaukee
*Stuff, Patricia J, Bonduel
*Teasley, Jack L, Milwaukee
*Todd, Paul C, Menomonee Falls
*Webster, Stephen B, La Crosse
*Wilson, Stuart D, Milwaukee
Young, Laurens D, Wood ■

Members of the State Medical Society of Wisconsin

American Academy of Allergy and Immunology is the new name for the American Academy of Allergy which voted the change at its business meeting in Montreal, Canada, in March. According to the newly elected president, I Leonard Bernstein, MD (Cincinnati, Ohio), "the addition of specialists in immunology to our membership has been a major reason for our rapid expansion in the past 15 years. We felt that we had to incorporate their interests into our society, and that this would best be accomplished by a formal change of name."

(The State Medial Society of Wisconsin has a Specialty Section on Allergy and Clinical Immunology.)

The American Academy of Allergy and Immunology reported that it is the largest professional organization in the field, numbering over 3,000 allergists, immunologists, and research scientists specializing in and dedicated to the diagnosis, care, and study of allergic diseases, including asthma, hay fever, and a number of diseases of the skin. The Executive Offices are located at: 611 East Wells Street, Milwaukee, Wisconsin 53202. Donald L McNeil is the Executive Director and Kim J Marggraf is the Associate Executive Director.

Wisconsin Society of Internal Medicine, in the March issue of its quarterly newsletter, reported the following: "The American Society of Internal Medicine has learned that the Department of Health and Human Services (DHHS) will appeal a US District Court ruling which declared the use of specialty screens illegal in Michigan. Shortly after the December 1980 decision—the result of a suit filed by the Michigan Academy of Family Physicians against DHHS, ASIM wrote a letter to DHHS Secretary Richard Schweiker urging appeal of the case. ASIM believes that specialty screens, which allow Medicare patients proper reimbursement when treated for complex problems requiring the skill and training of a specialist, are essential to assure proper recognition of the services and skills of internists. ASIM has filed an amicus brief March 9, 1982 which allows ASIM to present written arguments to the court in support of its position on specialty profiling."

The WSIM will hold its Annual Meeting September 9-11 at the Holiday Inn in downtown Green Bay. Featured topics include management of pregnancy associated problems (hypertension, hematologic abnormalities, diabetes, and valvular heart disease) and challenging case discussions. The socioeconomic program, conducted by Spence Meighan, MD, will provide a futuristic view of "The Promised Land."

A scientific program under the direction of Joseph J Mazza, MD* of Marshfield was presented at the May Annual Meeting of the State Medical Society of Wisconsin. It covered various cardiac topics including radionuclide scanning, angioplasty, and the use of lytic agents. ■

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RATES: 40¢ per word, with a minimum charge of $16.00 per ad. BOXED AD RATES: $32.00 per column inch. DEADLINE: Copy must be received by the 20th of the month preceding month of issue; e.g., copy for the August issue is due July 20. Send copy to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 800/362-9080.

Physicians Exchange

La Crosse—Dynamic 52-physician multispecialty clinic is recruiting in the following specialties: **Vascular Surgery, Neurology, Hematology/Oncology, Family Practice.** Strong in primary and secondary care, we have four active satellite clinics. Modern 350-bed hospital, with CT scanner and medical staff of 92 MDs including neurosurgeon, immediately adjacent to clinic building. La Crosse is a progressive, family oriented city of 50,000 in the beautiful Mississippi River Valley with a medical referral area of greater than 150,000. Exceptional cultural, educational and recreational opportunities locally. Contact: P S Shultz, MD, Medical Director, Skemp-Grandview-La Crosse Clinic, 815 S 10th St, La Crosse, WI 54601; ph 608/782-9760. 5-7/82

Family Practice Physician/or Primary Care Oriented Internist to join two family practice physicians and a Board certified surgeon in a group practice. Located in a community of 2,500 in southwest Minnesota. This medical clinic is supported by a modern 30-bed acute care hospital and 138-bed skilled long-term care facility. Guaranteed first year income, will pay travel expenses for interview. Interested physicians send curriculum vitae to William Wilson, Administrator, Springfield Community Hospital, PO Box 146, Springfield, Minn 56087 or call collect 507/723-4215 for more information. 5-10/82

Fifty physician multispecialty clinic in west central Wisconsin wants neonatologist, neurosurgeon, orthopedic surgeon, and otolaryngologist. Excellent cultural, educational, and recreational facilities. 90 miles from Minneapolis. Please contact James R Jepson, Administrator, Midelfort Clinic, Ltd, 733 West Clairemont Ave, Eau Claire, Wis 54702 or call 715/839-5266. 5-7/82

Otolaryngologist wanted, BE/BC to join multispecialty group in northern Wisconsin lakes region. Negotiable first year guaranteed salary; full partnership in second year. Full lab, x-ray and audiology services. Clinic located adjacent to modern hospital. Contact Dept 501 in care of the Journal. 5-7/82

General Practice. Well established and furnished office; Milwaukee, south side, will lease; in clinic with associated dentist. Doctor will introduce and retire; references required. Contact Dept 502 in care of the Journal. 5/82

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University of Wisconsin Department of Family Medicine
777 South Mills Street, Madison, Wisconsin 53715
Phone: 608/263-4095

1-12/82

Family Physician. An existing physician's practice located in Green Lake, Wisconsin. This is an active practice that includes obstetrics, pediatrics, and adult medicine. Cross coverage with other physicians, and hospital has full-time emergency room physician coverage. Financial package includes a minimum guaranteed net income the first year. Contact: Donald R Brezicka, Executive Director, Berlin Memorial Hospital, 225 Memorial Dr, Berlin, Wis 54923; ph 414/361-1313. 5-7/82

Orthopedic Surgeon. Our hospital has more work than part-time orthopedic surgeon can handle! We are an active, energetic medical staff in the progressive, prestigious Green Lake area of Wisconsin. Remuneration is a minimum guarantee of $90,000. Contact Michael Tieman, MD, Chief of Surgery, Berlin Memorial Hospital, 225 Memorial Dr, Berlin, Wis 54923; ph 414/361-1313. 5-7/82

Wausau Medical Center, SC, a 50-physician multispecialty group has openings for physicians in the following specialties: *Family Practice, OB/GYN, Otolaryngology,* and *General Surgery* with a fellowship training in *Peripheral Vascular Surgery.* Competitive first-year salary, incentive plan thereafter. Comprehensive fringe benefits. New facility near new hospital. Located in beautiful, quiet, central Wisconsin, metropolitan area of 65,000. Recreational opportunities abundant. For more information contact: K L Day, MD, Wausau Medical Center, SC, 2727 Plaza Drive, Wausau, Wis 54401, or call collect 715/847-3351. 3tfn/82

Dermatologist, Family Practitioner needed to join multispecialty group of 33 physicians dedicated to primary care in East Central Wisconsin community. City population 48,000, drawing area 100,000. Attractive income arrangements, association membership possible after one year, pension and profit sharing, extensive fringe benefits. Contact R B Windsor, MD, 1011 North 8th St, Sheboygan, Wis 53081; ph 414/457-4461. 5tfn/82

Internist wanted. Board certified or eligible with/without subspecialty, to practice in conjunction with a 6-member Internal Medicine Department in a 22-member multispecialty group. Present subspecialties: Gastroenterology and cardiology. The group is in Southeastern Wisconsin, in a city of 100,000 between two major metropolitan areas of greater than one million. If interested, please send CV to: Stephen L Wagner, Kurten Medical Group, 2405 Northwestern Ave, Racine, Wis 53404. All inquiries will be kept confidential. 3tfn/82

Surgeon with Thoracic general vascular training, Ophthalmologist, and ENT, to join a progressive multispecialty group of 17 physicians consisting of General/Family Medicine, General Surgery, Internal Medicine, OB-GYN, Ophthalmology, Orthopaedic Surgeon, Pediatrics/Adolescent Medicine, and Radiology. Subspecialties include: Pathology, Vascular Surgery, Cardiovascular Diseases, Gastroenterology and Endoscopy. We are located in a fast growing, scenic, lake country area between Milwaukee and Madison and can offer excellent hospital, schools, and recreational facilities. Full fringe benefit package. Contact: James F Dowd, Admin, Wilkinson Clinic SC, 915 East Summit Ave, Oconomowoc, Wis 53066; ph 414/567-4433. 9tfn/81

Physicians Exchange

continued

Wanted. Board certified or eligible orthopedic surgeon to practice in conjunction with a 5-member surgery department in a 22-member multispecialty group. Present surgical specialties: thoracic and vascular surgery, general surgery and urology. The group is located in the upper midwest, in a city of 100,000 between two major metropolitan areas of greater than one million. If interested, please send CV to: Stephen Wagner, Kurten Medical Group, SC, 2405 Northwestern Ave, Racine, Wis 53404. All inquiries will be kept confidential. 12tfn/80

Family Physician or Internist to join three-man family and general practice group in the heart of North Central Wisconsin vacationland. First year guaranteed salary. Numerous fringe benefits. Clinic across from hospital. Send CV to: O M Francisco, MD, 221 E Washington Ave, Tomahawk, Wis 54487; ph 715/453-2147. 5tfn/82

Family Practitioners and Internists. 40-bed hospital on the shores of Lake Superior in the Upper Peninsula of Michigan seeks additional staff in family practice and internal medicine. Year-round recreational area with opportunity for challenging medical practice. Office building, staff, and equipment negotiable. Contact William Hermann, Executive Vice President, Munising Memorial Hospital, Route 1, Box 501, Munising, Michigan 49862. p5-7/82

The Nicolet Clinic, SC, a young progressive 38-physician multispecialty group, has superb opportunities available for the practice of *General Surgery, Neurology,* and *Radiology.* Ideal family oriented community in metropolitan area with excellent schools, economy, culture and recreation for all four seasons. Located on northern Lake Winnebago. First year negotiable salary with option for full membership at nine months. Adjacent to modern regional hospital. Excellent benefits in addition to qualified profit-sharing plan and support for continued education. Contact in confidence: Curtis C Baltz, MD, Nicolet Clinic, SC, 411 Lincoln St, Neenah, Wis 54956; ph 414/727-4244. 3-6/82

General and Vascular Surgeon. Board eligible/certified to join 9-man multispecialty group in Southeastern Wisconsin. Well established, recreational setting. Adjacent to 150-bed hospital. Send CV to Administrator, Burlington Medical Center, 190 Gardner Ave, Burlington, Wis 53105. p3-5/82

General and vascular surgeon, FACS, Board certified, highly qualified, with several years of practice, would like to join an individual or group with an established practice in metropolitan Milwaukee area. Contact Dept 493 in care of the Journal. 3tfn/82

Physician wanted to perform light physicals on a full or part-time basis. Ideal job for retiring physician. Contact Mike Stough collect at 513/621-8728. 10tfn/81

The Racine Medical Clinic, a progressive cluster corporation of 25 physicians, is currently seeking an orthopedic surgeon and an invasive cardiologist. Full benefits, unlimited earnings and a full and exciting practice are offered. Please contact: Roger D Lacock, Administrator, Racine Medical Clinic, 5625 Washington Ave, Racine, WI 53406; ph 414/886-5000. 1tfn/82

Family Practitioner. Immediate need to associate with busy, Board certified family practitioner in Tomah. Modern local clinic and hospital and formal association with 52-physician multispecialty clinic in La Crosse. Tomah is an active, growing community of 7,000 with a medical service area of 20,000. Contact: P S Shultz, MD, Medical Director, Skemp-Grandview-La Crosse Clinic, 815 S 10th St, La Crosse, WI 54601; ph 608/782-9760. 5-7/82

Faculty Member Family Practice Program. The Black Hawk Area Medical Education Foundation is recruiting a Board Certified Family Physician to join its Family Practice Residency Program in Waterloo, Iowa. The program is community-based, affiliated with the University of Iowa College of Medicine, and part of the Iowa Network of Family Practice Residency Programs. The Waterloo metropolitan area has 125,000 people, four hospitals, and is well represented in the medical specialties. Applicants should have a MD degree, be eligible for licensure in Iowa, and should have several years of practice experience. Major duties include teaching residents in all aspects of patient care, including obstetrics, and also providing patient care. Other duties include some program administration and assisting in research from time to time. A salary in the range of $60,000 per year with an additional 20% fringe benefit package is offered. Other fringe benefits relating to retirement, moving expenses, and continuing education are provided. Please submit your resume to: Charles A Waterbury, MD, Program Director, Black Hawk Area Medical Education Foundation, 441 East San Marnan Dr, Waterloo, Iowa 50702; ph (319) 234-4419. Equal Opportunity Employer. 5-7/82

Family physician, Board Certified or Eligible, to join four-man family practice group in northwest Wisconsin. First-year guaranteed salary. New clinic building located adjacent to 46-bed hospital, in the heart of Wisconsin's vacationland. Call shared with other family practice physicians in area, weekend coverage contracted. Jeanne Chamberlain, Adm, Spooner Clinic Ltd, 707 Ash St, Spooner, Wis 54801. Ph 715/635-2151. 12/81; 1-5/82

Pediatric, Family Practice positions available in 13-member multispecialty group. Inquire: General Clinic of West Bend, Inc, 279 S 17th Ave, West Bend, Wis 53095. 2tfn/82

Locum tenens services. Wisconsin-licensed family physician available and also needed. Our Physicians do Office, Hospital, Emergency Room and OB work. Call or write: INTERHEALTH, Attn: J Slazek, 5695 Merry Lane, Excelsior, MN 55331; ph 612/474-4372. 4-6/82

Physician wanted to share fully equipped medical office, x-ray, lab, fully staffed, small community, northern Wisconsin. Contact Dept 496 in care of the Journal. 5tfn/82

Student Health Physician for campus of 10,000 students. Rare evening or weekend responsibilities. Salary negotiable. Good benefits. A nine-month position starting August 23, 1982. Send Curriculum Vitae to Charles Bass, MD, Director, Student Health Service, University of Wisconsin-Eau Claire, Eau Claire, Wis 54701. Affirmative Action Employer. Closing date June 1, 1982. 4-5/82

Emergency Physician, Appleton/Oshkosh: 8-man fee-for-service group is expanding. ER residency trained or ABEM certified physician preferred. Excellent staff backup, paramedics, telemetry. Above average salary. Numerous fringe benefits including corporation-paid retirement, malpractice, etc. Send CV to Thomas Loescher, MD, 2520 Crestview Drive, Appleton, WI 54911; ph 414/734-6351. 4-5/82

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Busy OB/GYN Practice—associated required. Board certified or eligible. Guaranteed salary for first year with fringe benefits. Mohammad Shafi, MD, 606 W Wisconsin Ave, Milwaukee, Wis 53202; ph 414/276-7632. 4-6/82

Medical Facilities

Clinic pharmacy wanted in Milwaukee or Ozaukee counties by an expanding group practice of pharmacists. Capital available. Contact Dept 500 in care of the Journal. 4-6/82

Milwaukee. Busy family medical center for sale. Will introduce. Good for teaching interns and residents in Family Practice. Contact: R Gonzalez, MD; ph 414/344-1120 or 414/476-8624. 3-8/82

Immediate solo practice available in Jefferson, Wisconsin, due to the recent death of Richard H Siedenburg, MD. Expandable building with three large lots available. Lease or purchase. Contact Miller Law Office, PO Box 417, Jefferson, Wisconsin 53549; ph 414/674-3345. g11tfn/81

Prime east Madison medical office space to share. 2000 sq ft. Fully equipped and well furnished. Private office and sound proof examining rooms. X-ray, lab, and physical therapy facility on premises. Equipped minor surgery room. Share rent and staff expenses on a 50-50 basis or prorated to your needs. For more information and appointment to view facility, call C A Gencheff, DO: 608/241-3451. 12/81-1/82*

For Sale. diagnostic equipment including Standard x-ray, Clay Adams blood chemistry analyzer, Accustat blood cell counter, centrifuge, Lumiscribe portable minigraph EKG, examining tables and cabinets, office furniture and equipment and other miscellaneous. Contact Dept 499 in care of the Journal or call 414/965-2600 after 8:00 AM. 3-5/82

For Sale. Narco Bio-systems Arterial Diagnostic Unit, with bi-directional doppler. Automatic cuff inflator, and cardiac monitoring. Excellent condition. Send response to Burlington Clinic, SC, 325 East Jefferson St, Burlington, Wis 53105. p4-5/82

Wanted: X-Ray Equipment. Ultrasonic and Diathermy Units in workable condition. Reasonable. Info: Call 414/444-7525. 5-7/82

Office spaces for rent. New professional building in Menomonie, Wis, city of 14,000, 70 minutes from Minneapolis/St Paul on Interstate 94. Building has dental offices. Excellent opportunity for private practice. Contact Ryder Realty, 815 6th Ave, Menomonie, Wis 54751; ph 715/235-8800. 5-7/82

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International Academy of Professional Counseling and Psychotherapy (IAPCP) is now accepting applications from qualified physicians for Diplomate Status. The Academy is a multidisciplinary organization dedicated to the worldwide pursuit of excellence in counseling and psychotherapy. The Academy does not give preference to any particular profession or theoretical orientation, but instead focuses upon identifying and certifying individuals with advanced competence in counseling and psychotherapy. Within the profession of medicine, any physician who has had a considerable amount of experience in counseling patients regarding emotional and behavioral problems may be qualified. It is not necessary to be a psychiatrist to be eligible for Diplomate Status in The Academy.

The Academy offers certification as a Diplomate in Professional Counseling and also as a Diplomate in Professional Psychotherapy. While licensing or certification by governmental agencies and training institutions generally establishes minimum levels of competence, The Academy certifies individuals who have demonstrated advanced professional competence in counseling and psychotherapy. Diplomate Status in The Academy indicates to both the public and to other professionals that an individual has been evaluated by The Academy as meeting its high standards for advanced professional competence.

A restricted grandfather period will be in effect until June 30, 1984, during which time the examination will be waived for qualified applicants. For additional information and application materials, contact The Academy, 2036 Blairmore Road, Lexington, Ky 40502 USA (516/546-6646).■

Meetings/CME Courses

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates: 40¢ per word, with a minimum charge of $16.00 per listing. BOXED LISTINGS: $32.00 per column inch. COPY DEADLINE for Continuing Medical Education listings is tenth of the month preceding the month of publication; e.g., copy for the August issue is due by July 10. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 800/362-9080. For listing of other meetings see the Special issue of the Journal of the American Medical Association: Continuing Education Courses for Physicians for period Sept 1, 1981 through Aug 31, 1982.

WISCONSIN

JUNE 4-5, 1982: *Diabetes Mellitus—1982,* Madison. Sponsored by University of Wisconsin School of Medicine, Department of Medicine; and University of Wisconsin-Extension, Continuing Medical Education. AMA Category I, AOA Category 2-D, AAFP, University of Wisconsin Extension Continuing Education Units. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

JUNE 6-10, 1982: *Managing Health Care Resources in the Competitive Environment of the 1980s,* La Crosse. Sponsored by Western Wisconsin Health Systems Agency, University of Wisconsin Extension, and the University of Wisconsin La Crosse Business Outreach Department. Guest speakers include, Dr Alain Enthoven, Stanford University; Dr Erik Ritman, Mayo Medical School; and Dr Larry Cummings, Northwestern University. Info: Thomas M Lynch, Conference Director, Western Wisconsin Health Systems Agency, 1707 Main, La Crosse, WI 54601; ph 608/785-9352.

JUNE 10, 1982: Annual Spring Tournament of the Wisconsin State Medical Golf Association at Old Hickory Country Club in Beaver Dam. Additional details: Ronald Oschman, Executive Secretary, phone 414/226-6151.

JUNE 7-11, 1982: *Cardiac Rehabilitation Workshop,* La Crosse. See details elsewhere in this section.

JUNE 10, 1982: *Dying With One's Rights On? The Mental Health Commitment Laws,* Pfister Hotel, Milwaukee. Sponsored by Department of Psychiatry, Mount Sinai Medical Center and co-sponsored by The Milwaukee Bar Association, Milwaukee Psychiatric Hospital, and the Wisconsin Psychiatric Association. Info: Susan R Reichard, Mount Sinai Medical Center, 950 N 12th St, PO Box 342, Milwaukee, Wis 53201; ph 414/289-8026. (Further details elsewhere in this section.)

JUNE 10-11, 1982: *New Therapeutics in Cardiology and Infectious Diseases,* Madison. Sponsored by University of Wisconsin-Extension, Dept of Continuing Medical Education; and University of Wisconsin, School of Medicine, Dept of Medicine. AMA Category I, AOA Category 2-D; AAFP, University of Wisconsin-Extension Continuing Education Units. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

JUNE 14-18, 1982: *Cardiac Rehabilitation Workshop,* La Crosse. See details elsewhere in this section.

JUNE 14-18, 1982: *15th Annual Postgraduate Course in Gynecological Pathology, Endocrinology, and Maternal-Fetal Medicine,* Medical College of Wisconsin, Alumni Center, Milwaukee. Guest faculty includes H W Jones Jr, MD; Georgeanna S Jones, MD; J D Woodruff, MD, and Robert C Young, MD. $500 enrollment fee will include 68 selected 35mm slides. Registration limited to 150. Approved 41 credit hours of Category I of AMA-PRA and AAFP. Also approved for 41 Cognates, Formal Learning, by the American College of Obstetricians and Gynecologists. Info: Richard F Mattingly, MD, Professor and Chairman of Gynecology and Obstetrics, Medical College of Wisconsin, 8700 West Wisconsin Ave, Milwaukee, Wis 53226.

DYING WITH ONE'S RIGHTS ON?: THE MENTAL HEALTH COMMITMENT LAWS

Thursday, June 10, 1982
Pfister Hotel, Milwaukee

A forum presented by the Department of Psychiatry, Mount Sinai Medical Center; and co-sponsored by: The Milwaukee Bar Association, Milwaukee Psychiatric Hospital, and The Wisconsin Psychiatric Association

The Presenters: *Jules Coleman, PhD,* Tucson, Ariz; *David Saicheck,* Milwaukee; *Alan A Stone, MD,* Cambridge, Mass; *Thomas Szasz, MD,* Syracuse, NY; *Darold A Treffert, MD,* Fond du Lac; *Mona Wassow, MSW,* Madison; and *Thomas Zander,* Milwaukee

Registration: $55. Info: Ms Sue Reichard, Mount Sinai Medical Center, 950 N 12th St, PO Box 342, Milwaukee, Wis 53201; ph 414/289-8026.

STATE MEDICAL SOCIETY OF WISCONSIN
Dates and Locations of Annual Meetings
1982-1992

All meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) and the new Hyatt Regency as the headquarters hotel with the exception of 1985, when the meeting will be held at the LaCrosse Convention Center.

1982—May 13-15	**1987—Mar 26-28**
1983—Mar 24-26	**1988—Apr 28-30**
1984—Mar 29-31	**1989—Apr 13-15**
1985—Apr 25-27	**1990—Apr 26-28**
1986—Apr 17-19	**1991—Apr 18-20**

1992—Apr 23-25

Meeting days will be Thursday and Friday; the first session of the House of Delegates will convene on Thursday, the second and third on Friday. Scientific programming will be on Friday and Saturday.

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701. Local telephone: 257-6781; toll-free in Wisconsin: 1-800/362-9080.

JUNE 16, 1982: *What's New in Alzheimer's Disease,* Mount Sinai Medical Center, Milwaukee. Info: Susan R Reichard, Mount Sinai Medical Center, 950 N 12th St, PO Box 342, Milwaukee, Wis 53201; ph 414/289-8200. (Further details elsewhere in this section.) g4-5/82

JUNE 16-AUGUST 4, 1982: *University Forum on Health,* eight weekly lectures on Wednesday evenings from 7-9 pm in Room 3650, Humanities Building, University of Wisconsin-Madison. See details elsewhere in this section.

JUNE 16-19, 1982: Annual Scientific Assembly of the Wisconsin Academy of Family Physicians, Radisson Hotel, La Crosse. Approved 20 credit hours Category 1 of AMA-PRA. Info: Robert H Herzog, Wisconsin Academy of Family Physicians, 850 Elm Grove Rd, Elm Grove, Wis 53122; ph 414/784-3656.

JUNE 17-23, 1982: *Fifteenth Annual Postgraduate Course in Gynecological Pathology, Cytogenetics and Endocrinology,* Pfister Hotel and Tower, Milwaukee. Sponsored by The Medical College of Wisconsin, Milwaukee. Fee: $500 enrollment fee will include 68 selected 35mm slides. Approved 42 credit hours of Category I of AMA-PRA and AAFP. Info: Richard F Mattingly, MD, Medical College of Wisconsin, 8700 West Wisconsin Ave, Milwaukee, Wis 53226.

JUNE 18-19, 1982: *Advances in Developmental Abnormalities: Clinical, Genetic, Radiological, and Pathologic Aspects* Madison. Sponsored by University of Wisconsin School of Medicine and University of Wisconsin-Extension, Continuing Medical Education. Approved 11 credit hours Category 1 of AMA and Extension Continuing Education Hours. Fee: $140. Info: Sarah Z Aslakson, Continuing Medical Education, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

JUNE 20-25, 1982: *Study Program on Rural Mental Health Services,* Memorial Union, Madison, Wis. Sponsored by University of Wisconsin-Extension Health and Human Services, Continuing Education in Mental Health, and The National Association for Rural Mental Health, Inc. Info: Gail Gladding, 414 Lowell Hall, 610 Langdon St, Madison, Wis 53706; ph 608/263-2088.

JUNE 24-25, 1982: *Obstetrical Events and Neonatal Brain Injury,* Wisconsin Center, Madison. Sponsored by Continuing Medical Education, Health Sciences Unit, University of Wisconsin-Extension and Departments of Family medicine and Practice, Pediatrics, Gynecology and Obstetrics, School of Medicine, University of Wisconsin, Madison, and Madison General Hospital and St Marys Hospital Medical Center. Twelve credit hours, AMA; AOA; CEU's ACOG applied for. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

JULY 12-16, 1982: *Cardiac Rehabilitation Workshop,* La Crosse. See details elsewhere in this section.

JULY 16-17, 1982: Wisconsin Society of Obstetrics and Gynecology, Leathem Smith Lodge, Sturgeon Bay.

JULY 23-24, 1982: *2nd Annual Common Emergency Care Problems: Managing the Unmanageable,* Wisconsin Center, Madison. Sponsored by University of Wisconsin-Extension, Department of Continuing Medical Education; University of Wisconsin Emergency Medical Services Program; and U S Department of the Army, Office of the Surgeon General. Approved 10 credit hours of AMA Category I; University of Wisconsin-Extension CEH's, 10 hours; AOA Category 2-D plus Emergency Medical Physicians applied for. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

JULY 30-AUG 1, 1982: *EKG Interpretation and Arrhythmia Management,* Abbey Resort, Lake Geneva. Fee: $245 physicians; $130/Nurses & Technicians. Approved 13 credit hours

Cardiac Rehabilitation Workshops

Offered through the joint effort of the La Crosse Exercise Program and La Crosse Lutheran Hospital/Gundersen Clinic, Ltd, six times throughout the year as follows:

March 1-5	**June 7-11**	**July 12-16**
April 19-23	**June 14-18**	**Sept 20-24**

Workshops provide an indepth understanding and experience of all aspects of cardiac rehabilitation and a thorough understanding of the organizational and administrative aspects of a cardiac rehabilitation program. Workshops will consist of didactic lecture with structured laboratory experiences and examinations. Accreditation through a number of agencies is offered. For further information contact:

Dr Philip K Wilson, Workshop Unit-La Crosse Exercise Program, Mitchell Hall/University of Wisconsin-La Crosse, La Crosse, Wis 54601; phone 608/785-8686

1982 UNIVERSITY FORUM ON HEALTH

Presented by the University of Wisconsin-Madison Medical School and the Schools of Allied Health Professions, Nursing, and Pharmacy, all components of the Center for Health Sciences.

Weekly lecture/discussions on Wednesday evenings from 7-9 pm in Room 3650, Humanities Building.

Wednesday evenings—June 16 to August 4

Eight outstanding speakers will focus on health from the perspective of personal, professional, and social responsibilities:

- June 16—Philip Lee, MD, University of California, *The Nation's Health: Individual and Social Responsibility*
- June 23—William Nolen, MD, Litchfield, Minnesota, *Surgery and Healing*
- June 30—Don E Detmer, MD, UW-Madison Professor of Preventive Medicine and Surgery, *Physician-patient Relationships*
- July 7—Charlotte Anderson-Smith, RPh, MS, UW-Extension, *Treat Yourself Right: Rational Self-medication*
- July 14—Nancy Watts, PhD, Education Provost, Massachusetts General Hospital, *Taking Control of Your Own Health?*
- July 21—Alfred E Harper, PhD, UW-Madison Professor of Biochemistry and Nutritional Sciences, *Diet, Nutrition and Health*
- July 28—Jerry J Noren, MD, UW-Madison Assistant Professor of Preventive Medicine, *Health and Environment*
- August 4—Catherine Murphy, RN, EdD, Boston, College, *Ethical Decisions in Health.*

Moderator: Joseph M Benforado, MD, Professor of Medicine, Center for Health Sciences.

All interested persons may attend free of charge, or may register for the Forum as a one-credit Summer Sessions course.

Further information: Howard L Stone, PhD, Director, Office of Educational Resources, School of Medicine, Medical Sciences Center, 1300 University Ave, Madison, Wis 53706 (phone: 608/263-4714).

WISCONSIN continued

Category I of AMA-PRA and prescribed AAFP; ACEP. Info: International Medical Education Corporation, 64 Inverness Drive East, Englewood, CO 80112; ph 800/525-8651 or 303/740-8445, ext 123. 4-6/82

AUGUST 6-8, 1982: Wisconsin Dermatological Society summer meeting, Lake Geneva, Wis. Info: Robert A McDonald, MD, 1313 Fish Hatchery Rd, Madison, Wis 53715.

AUGUST 14, 1982: *Fifth Annual Sports Medicine Program,* Waunakee. Sponsored by University of Wisconsin, Division of Orthopedic Surgery, Section of Sports Medicine, and University of Wisconsin-Extension Department of Continuing Medical Education. Approved 10 credit hours AMA Category I, AOA Category 2-D, AAFP, University of Wisconsin-Extension Continuing Education Hours. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

AUGUST 20-21, 1982: *Second Annual Green Lake Conference on Infectious Diseases.* Heidel House Resort, Green Lake, Wis. Sponsored by Berlin Memorial Hospital. Approved 12 credit hours of Category I. For more information contact: Linda E Nevers, Berlin Memorial Hospital, 225 Memorial Dr, Berlin, Wis 54923; ph 414/361-1313. 5-7/82

SEPTEMBER 9-11, 1982: Wisconsin Society of Internal Medicine and American College of Physicians joint meeting, Holiday Inn Downtown, Green Bay. Info: Kim Marggraf, Wisconsin Society of Internal Medicine, 611 East Wells St, Milwaukee, Wis 53202.

SEPTEMBER 20-24, 1982: *Cardiac Rehabilitation Workshop,* La Crosse. See details elsewhere in this section.

OCTOBER 16, 1982: Wisconsin Radiological Society, Concourse Hotel, Madison.

NOVEMBER 5, 1982: Wisconsin Orthopaedic Society, Olympia Resort, Oconomowoc.

GERIATRIC CONFERENCE
WHAT'S NEW IN ALZHEIMER'S DISEASE

Wednesday, June 16, 1982
Mount Sinai Medical Center
Milwaukee, Wisconsin

- The Background of Alzheimer's Disease, *Albert A Fisk, MD,* Medical Director, Wisconsin Regional Geriatric Center
- Neurotransmitters and The Etiology of Alzheimer's Disease, *Gregory L Schmidt, MD,* Assistant Professor of Psychiatry, UW Medical School, Milwaukee
- The Diagnosis of Alzheimer's Disease, *David S Dahl, MD,* Professor of Neurology, Milwaukee Clinical Campus, UW Medical School
- Neuropsychological Testing of Alzheimer's Disease, *Kerry Hamsher, PhD,* Director, Neuropsychology at Mount Sinai Medical Center
- Day Care for Alzheimer's Disease Patients: Alzheimer's Disease Day Hospital Program of Wisconsin Regional Geriatric Center, *Albert A Fisk, MD;* The Research Component, *Iris R Winogrond, PhD;* The Patient Program, *Barbara Keyes, RN;* The Family Education and Support Group, *Gregory Szpak, MSW*
- The Family and Alzheimer's Disease Patients, *Bella H Selan, MS,* Director of Late Life Services, Mount Sinai Medical Center
- Mentally Impaired Elderly in the Community, *Eugene M Dagon, MD,* Director of Geropsychiatry, Milwaukee County Mental Health Complex

Fees: $40, Physicians; $20, Nurses and Allied Professionals

Info: Public Relations Department at Mount Sinai Medical Center, 414/289-8026. g4-5/82

OTHERS

JUNE 14-16, 1982 (Canada): *Critical Care Medicine-1982,* Banff, Alberta. Info: Registrar, American College of Physicians, 4200 Pine St, Philadelphia, PA 19104.

JUNE 24-26, 1982 (Washington DC): *The Primary Care Physician and Cancer,* Hyatt Regency Washington on Capitol Hill. American Cancer Society National Conference is being held in cooperation with the American Academy of Family Physicians. No registration fee, advance registration is requested. Approved 17.5 credit hours of Category I of AMA-PRA and AAFP. Program is eligible for 17.5 credit hours in Category 2-D of the American Osteopathic Association. Info: Nicholas G Bottiglieri, MD, American Cancer Society National Conference, The Primary Care Physician and Cancer, 777 Third Ave, New York, NY 10017. g4/82

JUNE 26-JULY 10, 1982 (Austria/Monaco): *XIIth World Congress on Sports Medicine* in Vienna, Austria June 26-July 4 and *Post Congress Symposium* in Monte Carlo, Monaco, July 4-10. "Practical Application of Sports Medicine for Physicians, Trainers, and Coaches." Contact PO Box 66, Shawnee Mission, Kansas 66201 or call 800-255-6969. 2-5/82*

JULY 9-10, 1982 (Pennsylvania): *Achieving a Successful Medical Retirement* seminar, conducted by the American Association of Senior Physicians (AASP), in Denver. Seminar costs: $150 for AASP members; $175 for nonmembers. Contact: Conact: AASP, 536 North State St, Chicago, IL 60610; phone 312/644-3092.

JULY 29-AUGUST 1, 1982 (Illinois): *International Doctors in Alcoholics Anonymous, Annual Meeting.* Hotel reservations directly at Ramada the O'Hare Inn, 6600 N Mannheim Rd, Des Plaines, Ill 60018 or call 312/827-5131 or 800/288-2828. (Be sure to specify IDAA for special rates). Further information contact Secretary IDAA, 1950 Volney Rd, Youngstown, Ohio 44511; ph 216/782-6216. g2tfn/82

AUGUST 29-30, 1982 (Colorado): *Achieving a Successful Medical Retirement seminar,* conducted by the American Association of Senior Physicians (AASP), in Denver. Seminar costs: $150 for ASSP members; $175 for nonmembers. Contact: AASP, 536 North State St, Chicago, IL 60610; phone 312/644-3092.

OCTOBER 10-16, 1982 (Florida): AMA's 1982 CME/Golf Digest-Tennis Program at the Doral Country Club and Hotel, Miami. Reservation deadline: September 1. Contact Elaine M Tejcek at 312/751-6057 for details.

OCTOBER 11-14, 1982 (Hawaii): *World Medical Association Continuing Medical Education Meeting* in Honolulu. Held in conjunction with the annual scientific meeting of the Hawaii Medical Association. Topics of the meeting will include "Leprosy," "Evaluation of Methods of Continuing Medical Education," "Current Advances in Pharmacotherapeutics," "Health Care Manpower," "Current Technologic Advances," and

"Current Advances in the Disorders of the Central Nervous System." Approved 19 credit hours of Category 1 CME credit. Registration fee is $50. Info: World Medical Assn, North American Region, 536 N State St, Chicago, Ill 60610; ph 312/751-6230.

OCTOBER 31-NOVEMBER 6, 1982 (India): *First US-India Radiology Conference,* sponsored by the Medical College of Wisconsin (MCW), Milwaukee, Wisconsin, and the Indian Radiological Association, New Delhi. It is recognized by the Atomic Energy Commission of India, Bombay. Program director: Jagmeet S Soin, MD, associate professor of radiology and medicine at MCW. This CME course meets the criteria for 30 credit hours in Category 1 of the Physician's Recognition Award of the AMA and 30 credit hours of Liaison Committee on Continuing Medical Education Category I CME credits. Info: Jagmeet S Soin, MD, MCW, 8700 West Wisconsin Ave, Milwaukee, Wis 53226, or call toll-free 1-800-558-4355. In Wisconsin call 414/784-8430.

AMA

JUNE 13-17, 1982: Annual AMA House of Delegates, Downtown Chicago Marriott, Chicago, Ill.

JUNE 19-23, 1983: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 4-7, 1983: Interim AMA House of Delegates, Los Angeles, CA.

DECEMBER 5-8, 1982: Interim AMA House of Delegates, Miami Beach, Fl.■

Northwestern University Medical School
Alumni Center for Continuing Education

1982 Programs

All programs to be held at Northwestern University Medical School, 301 East Chicago Ave, Chicago, Ill 60611, except those noted in parentheses.

June 4-5: *Clinical Problems in Urology*
June 17-18: *Current Surgical Concepts*
Sept 9-11: *National Conference on Perinatal Addiction*
Sept 23-25: *Second Annual Congress Laser Neurosurgery* (Knickerbocker Hotel, Walton Place, Chicago)
Oct 1-2: *Anesthesia for High Risk Pregnancy*
Oct 25-27: *Fertility and Infertility*
Oct 28-30: *Clinical Neuroscience Symposia*
Nov 11-12: *Avoiding Perinatal Catastrophies*
Nov 19-20: *Hysteroscopy Workshop*
Dec 3-4: *Colposcopy for the Practicing Physician*
Dec 9-11: *Symposium on Cerebrovascular Insufficiency* (Drake Hotel, Walton Place, Chicago)

Neurosurgery Laser Workshops: **Aug 23-24; Nov 8-9**

Otolaryngology Head and Neck Laser Workshops: **June 6-7; July 18-20; Sept 12-14; Oct 31-Nov 2; Dec 5-7**

As an organization accredited for continuing medical education, Northwestern University Medical School designates these medical education activities as meeting the criteria for LCCME Category I. Info: Northwestern University Medical School-Alumni Center for Continuing Education, 301 East Chicago Ave, Chicago, Ill 60611; phone 312/649-8533.

Mental health seminars offered in June

It has been established that approximately 60% of those individuals who have emotional or mental health disorders are first seen by their family physician. For these patients the primary physician plays a vital role in identifying and assessing the degree to which individuals receive adequate mental health treatment.

The Winnebago Mental Health Institute, State Dept of Health and Social Services, and the State Medical Society of Wisconsin are sponsoring a series of seminars in June designed to assist physicians in increasing their knowledge base and expertise in making adequate assessments and appropriate referrals.

"Mental Status and Referral Update" is approved for three hours of Category I continuing medical education credit, and will be offered twice daily from 9:00 am to 12:00 pm and from 1:00 pm to 4:00 pm. Faculty will be led by Darold A Treffert, MD, Fond du Lac, executive director, Fond du Lac County Health Care Center, and Richard B Stafford, MD, clinical director, Outagamie County Human Services Center. Dates and locations for the seminars are as follows:

June 2 Sheraton Inn & Conference Center, Madison
June 9 Holiday Inn of America, Wausau
June 10 Radisson La Crosse Hotel, La Crosse
June 24 Winnebago Mental Health Institute, Winnebago
June 30 Milwaukee County Institutions Day Hospital Auditorium, Milwaukee

Registration is $25. For further information contact Steve Kearney, Director of Education, Winnebago Mental Health Institute, Box H, Winnebago, Wis 54985; phone: 414/235-4910, ext 316.■

"WATS" LINE FOR MEMBERS

As a service for its members, the State Medical Society of Wisconsin has a **toll-free** WATS line (Wide Area Telecommunications Service) to provide member physicians with quick and easy access to SMS staff. The in-WATS line can be used to contact anyone at SMS headquarters (330 East Lakeside Street, Madison) from anywhere within the State of Wisconsin between the hours of 8:00 am and 4:30 pm weekdays. The number to dial is:

1-800-362-9080

News You Can Use

By EARL THAYER, Secretary/BERNIE MARONEY, Assistant Secretary

LOST STAFF PRIVILEGES REPORTABLE. A recently enacted state law requires hospitals to report to the Medical Examining Board peer investigation information which results in a physician's hospital staff privileges being lost or reduced for 30 days or more, or which results in a physician resigning from the hospital staff for 30 days or more. ¶Chapter 135, Laws of 1981, which became effective March 31, 1982, requires hospitals to notify the Medical Examining Board within 30 days after the loss, reduction, or resignation takes effect. Temporary suspensions due to incomplete records need not be reported. ¶Within 30 days after receiving a hospital report, the Medical Examining Board must notify the physician, in writing, of the substance of the report. The physician and the physician's authorized representative may examine the report and may place into the record a statement, of reasonable length, of the physician's view of the correctness or relevance of any information in the report. An action may be instituted in circuit court to amend or expunge any part of the hospital report. ¶If the Medical Examining Board determines a hospital report is without merit or that the physician has sufficiently improved his conduct or competence, the Board must remove the hospital report from the physician's record. ¶If no hospital reports are filed against a physician for two consecutive years, the physician may petition the Board to remove any prior reports, unless those reports are related to a finding of unprofessional conduct against the physician. ¶Hospitals may request information relating to a physician's loss, reduction, or resignation of staff privileges from other hospitals prior to admitting the physician to the medical staff. ¶Introduced at the request of the State Medical Examining Board as Senate Bill 68, the law is intended to prevent the migration of physicians who lose attending privileges at one hospital and to shortly thereafter receive approval for attending privileges at another, unsuspecting hospital. ¶The system requires the Medical Examining Board to act as a clearinghouse for the accumulation and dispersal of disciplinary actions taken by hospitals against physicians.

MD EMPLOYMENT OF PHYSICAL THERAPISTS LEGAL. Employment of a physical therapist by a medical services corporation is not a violation of the statutes, the Attorney General of Wisconsin has ruled. In an opinion issued April 14, 1982, the Attorney General ruled that there is no violation of the fee-splitting statutes in such situations where the physician bills the patient for his own services and that of a PT providing "the billing identifies the physician and PT providing the services and states an accurate dollar figure for the respective services." The opinion explains that the billing for the services of the PT may include amounts for salary, fringe benefits, and operating expenses in connection with the operation of the corporation. Copies of the opinion are available from the State Medical Society of Wisconsin.

PHYSICIANS MUST PROVIDE INFORMATION ON WORKER'S COMPENSATION PATIENTS. In the 1981 session of the Wisconsin Legislature an amendment was passed to the Worker's Compensation Act which clarifies the right of employees, employers, Worker's Compensation insurers and of the Department of Industry, Labor, and Human Relations to have access to information and written material related to the care, treatment and physical condition of a Worker's Compensation claimant. The amendment reads as follows: "*102.13 (2) An employee who reports an injury alleged to be work-related or files an application for hearing waives any physician-patient privilege. Notwithstanding ss. 51.30 and 146.82 and any other law, any physician, chiropractor, podiatrist, hospital or health care provider shall, within a reasonable time after written request by the employee, employer, worker's compensation insurer or department or its representative, provide that person with any information or written material reasonably related to any injury for which the employee claims compensation.*" According to the Worker's Compensation Division, the access to information related to the care, treatment, and physical condition of the employee is essential to permit such prompt and regular payments.

WHCLIP BOARD APPROVES 75% PHYSICIAN RATE INCREASE. The Board of Governors of the Wisconsin Health Care Liability Insurance Plan (WHCLIP) in March voted to increase physician premium rates by approximately 75%. The Board also okayed a motion to increase physician fee assessments for the Patients Compensation Fund by about 68%. These rate changes do not necessarily translate into a 75% or 68% rate increase for each physician specialty. The Board is currently reevaluating contributions made by each physician specialty to the plan and the fund. The Board said the increase was necessary in light of an increase in the frequency and severity of claims being filed against WHCLIP. Originally, the plan's actuaries had recommended a rate increase of 150%. ■

Bactrim™
(trimethoprim and sulfamethoxazole)
succeeds

Bactrim is useful for the following infections when due to susceptible strains of indicated organisms (see indications section in summary of product information):

Expanding its usefulness in antimicrobial therapy

in recurrent UTI...
a continuing record of high clinical effectiveness against common uropathogens

in acute otitis media in children...
effective against both major otic pathogens...with *b.i.d.* convenience

in acute exacerbations of chronic bronchitis in adults...
clears the sputum and lowers its volume...on *b.i.d.* dosage

in shigellosis...
faster relief of diarrhea than with ampicillin[2]

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. Limited clinical information presently available on effectiveness of treatment of otitis media with Bactrim when infection is due to ampicillin-resistant *Haemophilus influenzae.* To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.

For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae or Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.

For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.

Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: *General:* Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:

Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.

Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.

For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.

ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:

Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days.

PNEUMOCYSTIS CARINII PNEUMONITIS:

Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100; Prescription Paks of 20 and 28. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40. *Pediatric Suspension,* containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); cherry-flavored—bottles of 100 ml and 16 oz (1 pint). *Suspension,* containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).

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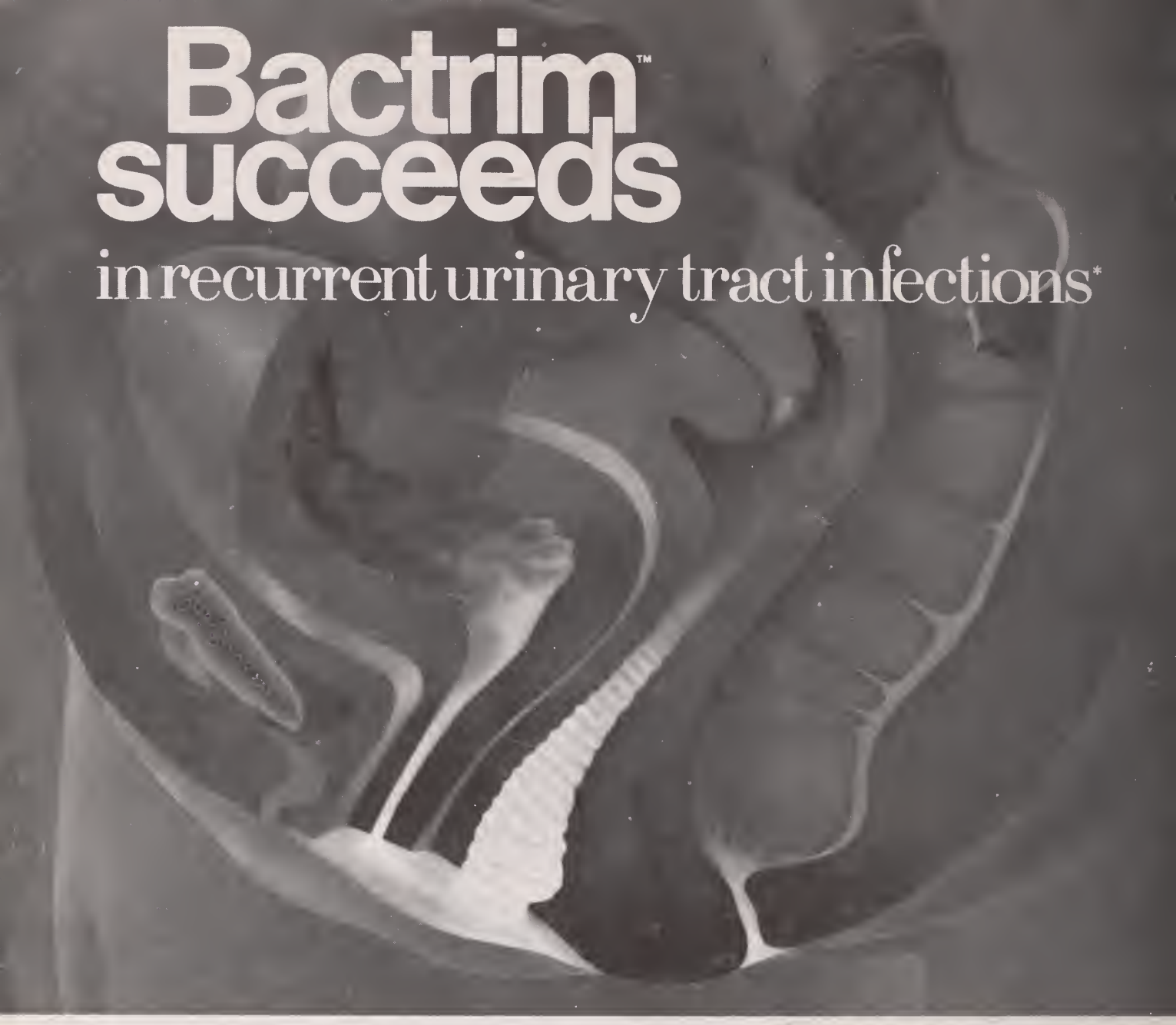

Bactrim™ succeeds

in recurrent urinary tract infections*

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1. Rubin RH, Swartz MN: *N Engl J Med 303* 426-432, Aug 21, 1980. 2. Data on file, Medical Department, Hoffmann-La Roche Inc.

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JUNE 1982

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The Physician's Sleep Glossary

Some common sleep laboratory terms

poly•som•no•graph. An instrument which simultaneously records by electrodes physiological variables during sleep—for example, brain activity (EEG), eye movements (EOG), muscle tonus (EMG) and other electrophysiological variables. These readings indicate precisely when patients fall asleep, how many wake periods they experience, the quality of sleep and the duration of sleep.

sleep la•ten•cy. The period of time measured from "lights out," or bedtime, to the commencement or onset of sleep.

wake time af•ter sleep on•set. Intervals of time spent awake between onset of sleep and the end of the sleep period. The polysomnograph registers the length and frequency of the intervals.

to•tal sleep time. The amount of time actually spent in sleeping. This is estimated by subtracting wake times from the period encompassed by the onset and the termination of sleep.[1]

REM/NREM. 1. REM, or rapid eye movement, sleep is "active"—characterized by increased metabolic rates, elevated temperature and arousal-type EEG patterns. 2. NREM, or non-rapid eye movement, sleep represents "quiet" sleep stages. There are four distinct stages of NREM sleep.[2]

re•bound in•som•nia. A statistically significant worsening of sleep compared to baseline on the nights immediately following discontinuation of sleep medication.[3]

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References: 1. Williams RL, Karacan I: Introduction, chap. 1, in *Sleep Disorders: Diagnosis and Treatment*, edited by Williams RL, Karacan I, Frazier SH. New York, John Wiley & Sons, 1978, p. 2. **2.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **3.** Kales A *et al: JAMA 241*:1692-1695, Apr 20, 1979. **4.** Kales A *et al: J Clin Pharmacol 17*:207-213, Apr 1977 and data on file, Hoffmann-La Roche Inc., Nutley, NJ. **5.** Kales A: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **6.** Kales A *et al: Clin Pharmacol Ther 19*:576-583, May 1976. **7.** Kales A, Scharf MB, Kales JD: *Science 201*:1039-1041, Sep 15, 1978. **8.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. **9.** Dement WC *et al: Behav Med 5*(10):25-31, Oct 1978. **10.** Vogel GW: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **11.** Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington, DC, May 3-7, 1971. **12.** Pollak CP, McGregor PA, Weitzman ED: The effects of flurazepam on daytime sleep after acute sleep-wake cycle reversal. Presented at the 15th annual meeting of the Association for Psychophysiological Study of Sleep, Edinburgh, Scotland, June 30-July 4, 1975. **13.** Zimmerman AM: *Curr Ther Res 13*:18-22, Jan 1971. **14.** Kales A, Kales JD: *Pharmacol Physicians 4*(9):1-6, Sep 1970. **15.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ.

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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

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Hell no, I won't---

CURRENTLY THERE IS considerable controversy over the proposed plan that the US Defense Department place war casualties in civilian hospitals in the United States. The issue is a plan called Civilian-Military Contingency Hospital Systems (CMCHS) in which the Pentagon is asking hospitals all over the country to participate. The Pentagon requests that a percentage of beds in civilian hospitals be made available in the event of a future large scale war. The assumption is that "a future large scale war overseas will probably begin and end very rapidly producing casualties at a higher rate than any other war in history." The plan is based on the further assumption that many wounded men will have to be flown back to the United States for treatment since military hospitals overseas could not cope with this influx of casualties.

The basic plan calls for placing the first casualties in hospitals on both coasts, then in major metropolitan areas in the midwest, and finally in smaller midwestern hospitals.

The responses from hospitals throughout the United States certainly cover a wide range. For example, in some situations the hospital administration has agreed to go along with the plan without consulting the medical staff at all. In others the hospital administration has rejected the plan without consulting the medical staff. For medical staffs that have been consulted, there is likewise a split decision. Some have agreed to accept, others to reject, and still others to engage in a lengthy debate. This last situation seems most likely to occur in academic medical circles.

Some activist physicians, in particular, vigorously and vocally oppose the plan because they feel that acceptance would encourage nuclear war. At the risk of appearing as a lion in the Daniel's den, it is my opinion that a group of physicians declining to go along with the plan is not going to greatly influence world politics.

However, when the chips are really down, it is extremely unlikely that the administrations or medical staffs of any hospital in this country would reject casualties from any source. An alternative was proposed in which extensive military hospitals would be built and then set aside on a standby or contingency basis pending their future use. This would be an extremely costly and inefficient procedure. In any event, the plan was not proposed to cope with large scale nuclear war casualties because casualties of such devastation are beyond medical help and really not a consideration with the Defense Department plan.

Certainly no one in medicine condones nuclear warfare. —VSF

Multimillionaires

AN OUT-OF-STATE attorney recently submitted an article to the *Wisconsin Medical Journal* for possible publication. It was entitled "The Captive Malpractice Concept" or "How A Doctor Can Become A Multimillionaire Using His Own Malpractice Insurance."

The concept involved a number of physicians paying premiums of $30,000 and setting up an off-shore insurance affiliation with tax-free benefits. If the plan was followed, a physician could become a multimillionaire over a 25-year period.

Wisconsin physicians have been fortunate in that they have not had to pay an annual premium for medical malpractice insurance in the $30,000 range. Even in the upper risk brackets the current annual premium runs $5,000 to $6,000 a year. Wisconsin physicians will continue to have a good deal when premiums increase in 1982 as no doubt they will. There are over 3,100 physicians enrolled in the Wisconsin Health Care Liability Insurance Plan (WHCLIP). The Board of Governors of the plan has announced that $7.5 million will be returned to physicians who have been insured under that plan. This large amount is from excess premiums collected over the years and earnings generated by those premiums.

The proposed article was returned to the attorney. It was spaced even farther out than at least two other plans that had been proposed in the past by Wisconsin physicians who had hoped to reap great returns in the medical liability insurance field. —VSF■

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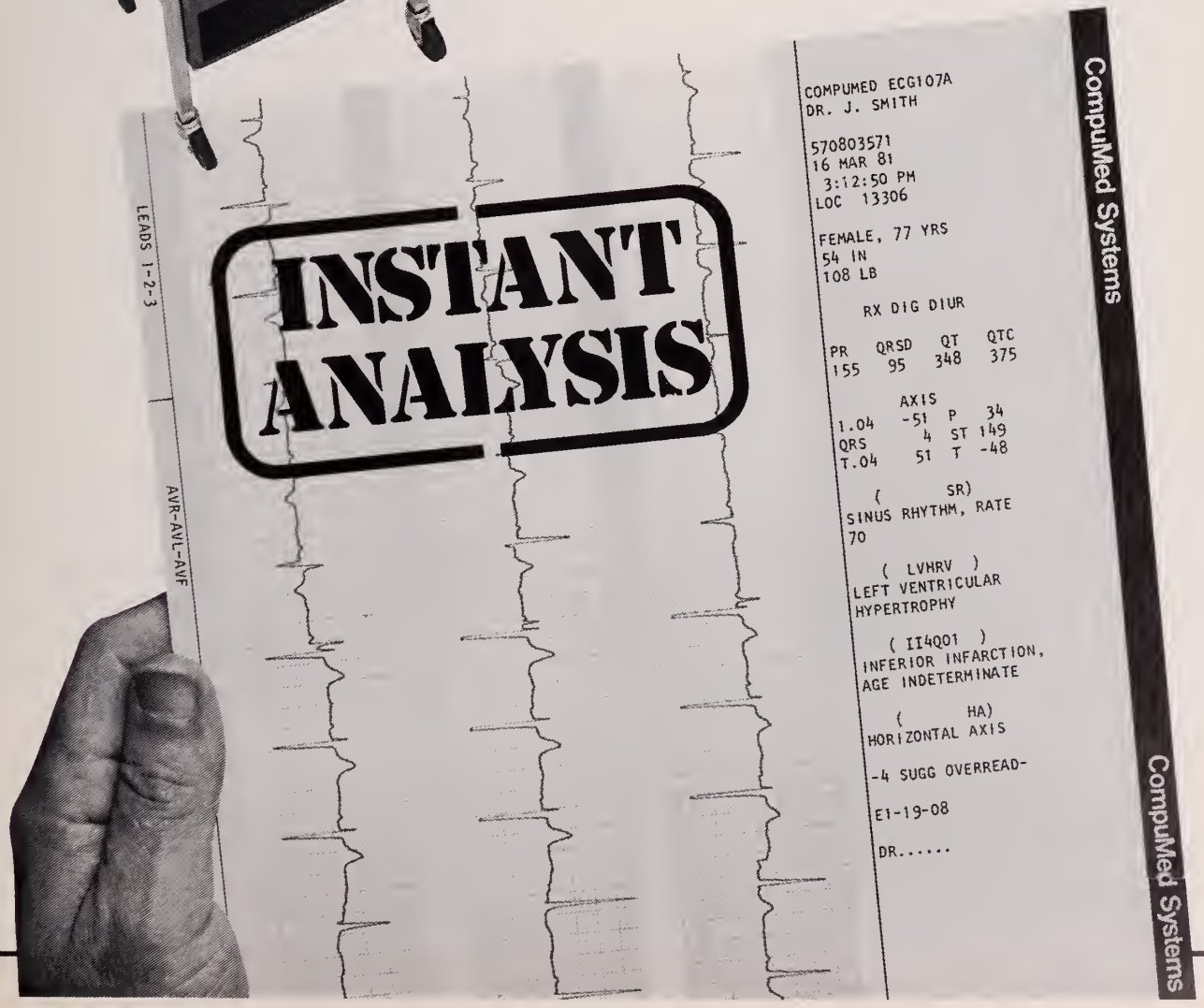

Letters

The Editors would like to encourage physicians to contribute to the LETTERS section where they can ventilate their frustrations as well as opinions. This feature is intended to be lively and spirited as well as informative and educational. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address correspondence to: The Editor, Wisconsin Medical Journal, Box 1109, Madison, Wis 53701.

New law on abuse, diversion of prescription drugs

TO MY COLLEAGUES: On April 21, 1982 the Governor signed into law several important changes dealing with abuse and diversion of prescription drugs. The changes that relate to physicians are provided for your information along with some observations on trends in the prescription drug diversion problem.

- Pentazocine (Talwin 50 and Talwin injectable) is moved from Schedule III to Schedule II. This means that as of April 21, 1982 prescriptions for Talwin must be in writing, are not refillable, and may be for a maximum 34 days' supply or 120 dosage units, whichever is less. Talwin Compound remains in Schedule III. These additional restrictions became necessary because of increasing practitioner diversion. Talwin and pyribenzamine (T's and Blues) are injected together as a heroin substitute.

- The present informal diversion prevention and control of the Controlled Substances Board Program is now a statutory requirement. The Board will work closely with enforcement and licensing authorities, including the Medical and Pharmacy Examining Boards, to detect and respond to diversion of controlled substances by physicians and pharmacists.

Passed by the Legislature unanimously, both of these changes signify Wisconsin's commitment to solving problems of controlled substances diversion. Moving Talwin to Schedule II is one part of the four-part strategy to stop the epidemic of abuse of "T's and Blues" in Wisconsin.

The other parts are law enforcement action against organized crime participants in Talwin diversion; removal of Talwin from the Medical Assistance Program reimbursement; and discipline of physicians and pharmacists who aid diversion of Talwin. Representatives of the Controlled Substances Board recently met with the Medical and Pharmacy Examining Boards and the Secretary of the Department of Regulation and Licensing to appeal for swift action against licensees who divert controlled substances to illicit use.

Because of the anticipated reluctance in availability of Talwin due to this more restrictive scheduling, and because of other emerging trends in the ever-changing collage of the drug scene, physicians and pharmacists should always be on the alert for increasing demands by drug abusers for a variety of controlled substances. Already, increased diversion of Dilaudid has been documented in Wisconsin. Other trends occurring nationwide, which will impact on Wisconsin, include abuse of codeine preparations and the use of another heroin substitute called "loads" which is an injected combination of Doriden (glutethimide) and codeine compounds.

The diversion of prescription controlled substances to illicit uses can and does result in increased morbidity, criminal activity, and admissions to drug abuse treatment programs in every community. Physicians should be cautious with patients with a history of drug abuse and should be suspicious of patients unfamiliar to them who request specific drugs that are controlled substances.

If you have any questions or concerns, please direct them to me or the Board staff, Mr David Joranson at the Board office:

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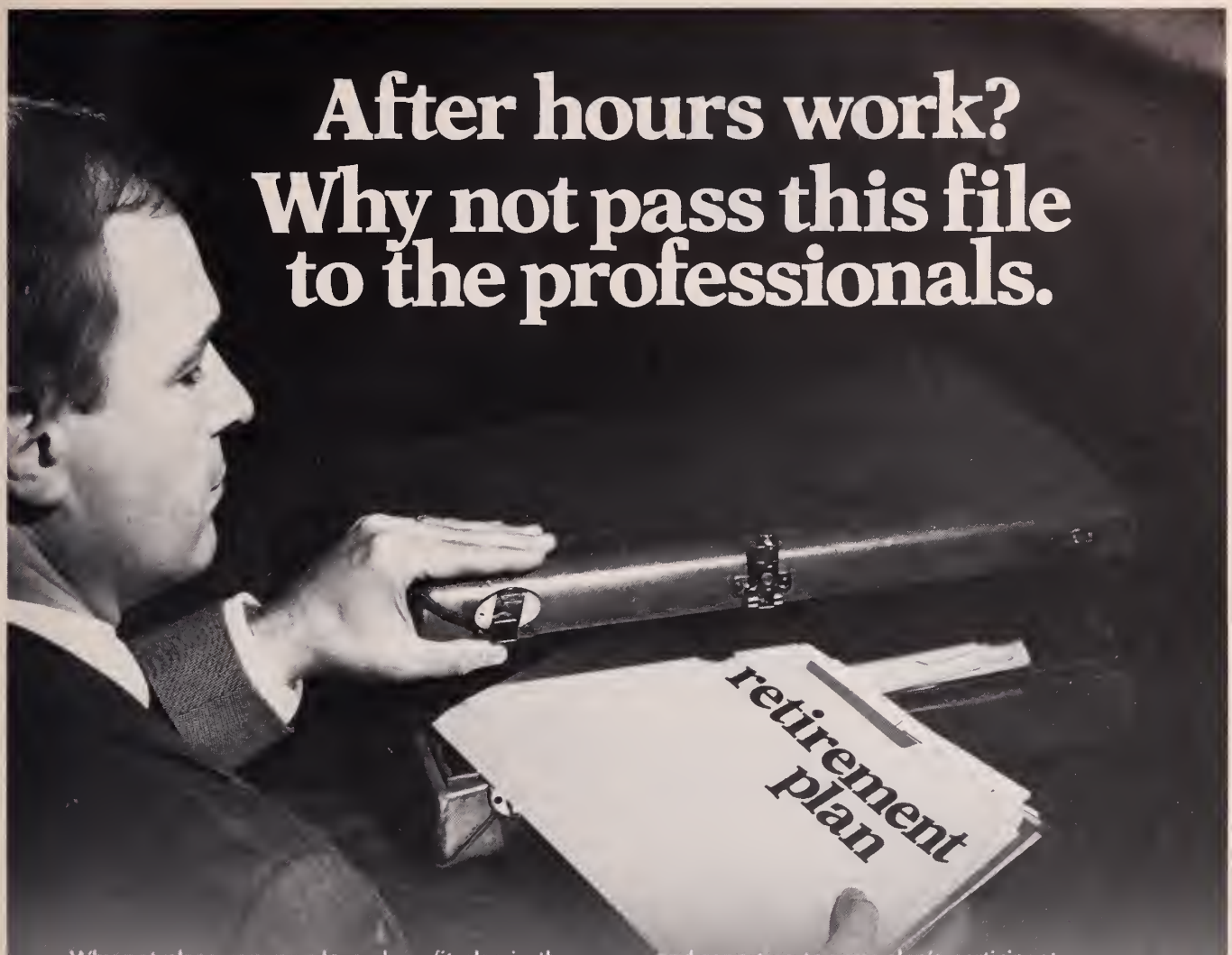

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THE QUESTION OF

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Communicating with the computer

John H Halton, MA, DPhil, FIMA, FBCS, Madison, Wisconsin

IN THE LAST ARTICLE, we examined a diagram (Figure 1) of the logical anatomy of a computer, which divided it into three main parts: (1) the CPU (or *central processing unit*), (2) the *memory* (main memory, MM, and extended memory, EM), and (3) a variety of I/O (*input* and *output*) devices. The first two parts of the triad were described, and we now come to the third.

(3) The *I/O devices* are the computer's link with the outside world. In large main-frame computers, we see *paper card* (as in Hollerith or 'IBM' cards) and *paper tape* readers and punches: the perforations in the paper carry the information. Increasingly in large computers and almost universally in small ones, the main input is from the *keyboard* of a *terminal.* This is much like a typewriter keyboard, and depressing any key sends an 8-bit code to the computer. When the computer is waiting for input from this terminal, it reads the code and interprets it as a datum; when it is busy, either the message is lost or it is held in a 'buffer' for subsequent input (this depends on how the connection is made and what the computer is made to do). It is quite common for the computer to be connected to several terminals, all competing for its attention. This is called *time-sharing.* The computer cycles around the terminals, looking for their several inputs and dividing its CPU time among them. The main output of the computer is to the display devices of the terminals; these are either *video displays* (cathode ray tubes, CRT, just like the screens of black-and-white or color TV sets; indeed, simple micros sometimes use ordinary television sets as display devices) or *printers* (in so-called *hard-copy terminals*). Of course, the computer may be connected to additional video displays and printers, of different qualities, as well as to *plotters,* a kind of printer for drawing graphs and diagrams. Many types and speeds of printers exist.

Other input devices, such as audio amplifiers (receiving signals from radio tuners, record players, etc), video receivers and recorders, laser disk drives, and a variety of scientific instruments, can all be classified as *transducers* (devices which transform physical quantities such as position, conductivity, pressure, temperature, vibration frequency or amplitude, into electromagnetic impulses) linked to *digitizers* (which convert such impulses into sequences of zero/one pulses). Output from the computer can similarly follow the reverse process, yielding visible or audible results, or the control of mechanical or electrical equipment. Thus computers can draw pictures (often, moving pictures), make music and other sounds, and can control appliances, machinery, and whole manufacturing processes.

In order to connect *remote terminals* to a computer, use is often made of telephone lines; and, for this purpose, one employs a device called a *modem* (for 'MOdulator/DEModulator'), which converts the computer's digital signals to and from telephone audio signals. This has a cradle shaped to hold the ear and mouth pieces of a telephone's hand-set. It is also possible to connect several computers in this way. This is called the formation of a computer *network.* Of course, computers may also be connected by cable, fibre-optics, or microwave link.

It should be noted that terminals usually, and other I/O devices often, themselves contain computers of varying degrees of power and complexity; so that even a multi-user computer with a central CPU may still be seen as a kind of computer network, in its own right. The computers in I/O devices such as terminals or printers are often referred to as *peripheral processors* (PP). Many networks do not have a central computer at all; but are simply a collection of independent computers, linked for the sharing of information and, sometimes, computing capabilities. Often, they permit the exchange of messages (*computer mail*)

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and the pooling of data (*distributed data-base*). They may also share a common bank of memory, accessible to all. Finally, since the invention of computer networks, designers have been investigating the possibilities of computers made up of an array of CPUs (*multicomputers, parallel processors, distributed processing*). These new ideas are very powerful and far-reaching: they will probably revolutionize our ideas of computers and of their applications, in the next few years.

I mentioned that the various peripheral devices are connected to the CPU without examining how. In fact, this may be done in several ways. We can simply have a separate connection (or *port*) for each device, but this limits rather severely the number of devices that may be connected to the CPU. Another way is to have a single *bus* (or connection) to which any number of devices may be attached. The information signal must then carry an appropriate *address*. The bus receives all sig-

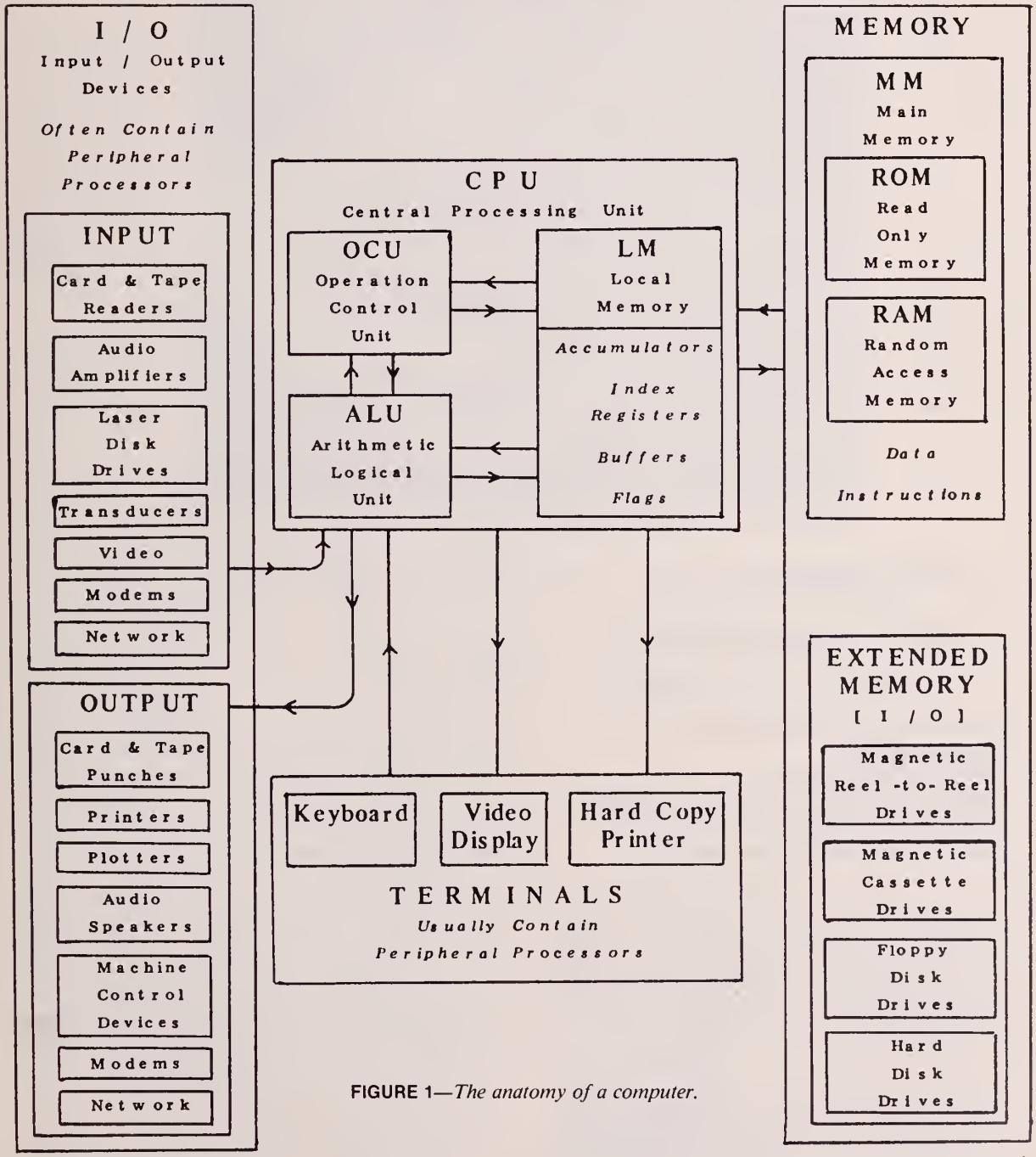

FIGURE 1—*The anatomy of a computer.*

nals, and individual devices (including the CPU) seek out and decode only those addressed to them. It is also possible to have a *switching device,* which receives addressed data and directs them to the appropriate recipient device, rather like a central post-office. The decision on what communication arrangements to adopt is made on the basis of considerations of cost, capacity, and speed.

It is often the case that the several devices forming a computer or a computer network have their data coded in different ways. It is then the job of the CPU(s) and PPs to share the work of interpreting signals into appropriate codes for each machine. This is broadly termed the problem of *interfacing* devices. Sometimes, the solution is to have a standard code or structure for the communications device (one meets the S-100 bus, the RS-232 serial port, the ASCII character-code, and so on). Another interfacing problem arises from the difference in the rate at which different devices can send and receive information (this is measured by the *baud rate,* named after Baudot, the inventor of the first five-hole paper-tape code; one baud is one bit transferred per second; hence kilobaud, kb, and megabaud, Mb; typical rates range from 200 baud to 200 kb). One solution is to send each piece of information (usually one character at a time, which takes 8 to 10 bits) only when the last has been acknowledged (this is referred to as a *handshake*); this is sure, but slow. Another way is to use a storage *buffer* in which a large batch of information is accumulated for fast transmission, thus not wasting the time of the faster device. Yet another approach is to connect several slow devices to a fast one and weave all their communciations together into a fast message for the rapid device to unravel (*multiplexing:* this is used in time-sharing a CPU among several terminals).

One last kind of choice must be mentioned: some channels of communication are *serial* (they transmit one bit at a time), while others are *parallel* (they can transmit a byte or a whole word at a time); the latter are obviously faster, more complex, and more expensive. When devices are connected by cable, the degree of parallel communication is exhibited in the width of a flat ribbon cable, carrying several wires, side by side, and in the number of pins in the plugs and sockets by which they are connected to the machines. Parallel transmission is a variation on multiplexing.

What we have described is generally referred to as the *hardware* of a computer. By contrast, the programs which make the computer work, the 'soul' of the machine, as opposed to the hardware 'body,' are collectively called its *software.* Inevitably, there came to be programs which were *hard-wired* (in the now outdated phrase) into the computer, in the form of ROM. These are termed *firmware.* A computer without software is a helpless set of circuits, and the expertise required to create the basic software which will bring the machine to useful life is comparable to that required to design the machine itself. Indeed, these days, computers are designed in cooperation between *computer architects,* who design what the computer will do, *hardware engineers,* who design how it will be constructed to be able to do it, and *software engineers,* who design and program the *operating system* which will run the machine. Beyond this, the computer will also need *application software* of many kinds, to enable it to do a variety of jobs, such as file-handling, accounting, statistics, payrolls, inventories, complex graphic displays, games, and so on. Typically, the application software is written (*ie,* programmed) by the end-users (if they are sophisticated enough) or firms of consultants and programmers and system analysts, often called *software houses.* Sometimes, a software house will produce part or all of an alternative operating system, or an additon to an operating system, to make a computer more flexible or more efficient than the manufacturer's own software system allows it to be.

The next article will focus on a brief description of computer languages and software.■

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Carotid-cavernous fistulae and their current therapy. . .

Michael J Feifarek, BS; Richard E Appen, MD; and **Charles M Strother, MD,** Madison, Wisconsin

ABSTRACT. *There are two varieties of carotid-cavernous fistulae: (1) those involving small meningeal branches of either the internal or external carotid artery ("dural" fistulae) which usually arise spontaneously and result in mild symptoms, and (2) those involving the internal carotid artery itself ("direct" fistulae) which usually occur following trauma and result in more profound symptoms. We report a patient with a "direct" fistula treated by obliteration of the fistula with detachable intravascular balloons, the current treatment of this condition. Ocular signs and symptoms are discussed.*

CAROTID-CAVERNOUS fistulae, abnormal communications between either the internal or external carotid artery and the cavernous sinus, have been recognized since 1809.[1] Approximately 75% occur following trauma and 25% arise spontaneously.[2] These fistulae permit escape of arterial blood under high pressure into a venous space, the cavernous sinus. Because the blood contained in the cavernous sinus is extradural in location and is enclosed by the strong walls of the dura, these fistulae do not result in intracranial hemorrhage.[3] Instead, the blood flows retrograde out of the sinus, reversing the usual pattern of venous flow. The resultant signs and symptoms are a consequence of these hemodynamic changes. The purposes of this report are to review carotid-cavernous fistulae, their symptoms and treatment, and to discuss the advantages of treatment with detachable intravascular balloons. The following case report illustrates many of these considerations.

CASE REPORT. In the spring of 1979, a 25-year-old man was struck in the left orbit with a fist and subsequently noted "rushing" sounds in his left ear. Six months later he developed diplopia, blurred vision, and exophthalmos of the left eye. In May 1980 neuroophthalmologic examination revealed visual acuity of 20/15 for the right eye and 20/20 for the left. The left eye was injected (Fig 1A) and had a soft pulsation synchronous with the pulse. Exophthalmometry readings were 17 mm for the right eye and 26 mm for the left. A loud bruit was audible over the entire head. There was a left VI nerve paresis. Intraocular pressure was 19 mmHg in the right eye, and 36 mmHg in the left. Funduscopic examination revealed mild dilation of the retinal veins of the left eye (Fig 1C).

Computed tomographic (CT) scan showed a markedly enlarged left superior ophthalmic vein. Left carotid arteriography revealed an internal carotid-cavernous sinus fistula (Fig 4A). Over the next two months, pain in the left eye developed and the bruit became louder. Prolapse of the chemotic conjunctiva occurred

FIGURE 1—*Appearance of patient in May 1980, showing proptosis and conjunctival injection of the left eye (A), the normal right fundus (B), and mild dilation of the retinal veins of the left fundus (C).*

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and increased retinal congestion and hemorrhage developed (Fig 2). Because of these changes it was elected to occlude the fistula with an intravascular detachable balloon.

In July 1980 a balloon catheter was introduced through the femoral artery and two silicone rubber balloons were inflated and detached in the cavernous sinus. Arteriography showed only slight persistence of the fistula, and it was elected to defer further treatment. Upon discharge from the hospital three days later, the subjective and objective bruit had ceased and the left eye was less congested.

Over the next several months, however, ocular congestion persisted and a bruit again became audible over the left globe. Visual acuity of the left eye diminished slightly to 20/30, and there was swelling of the left optic disc and increased retinal hemorrhages. Arteriography confirmed increased flow through the fistula.

In October 1980 two additional balloons were successfully detached in the left cavernous sinus. Postoperative arteriography showed nearly total occlusion of the fistula (Fig 4B) and the bruit had disappeared. There was gradual resolution of the orbital and retinal congestion.

Eleven months later in September 1981, visual acuity of the left eye had improved to 20/20. No bruit was present and the proptosis was reduced with exophthalmometry readings of 17 mm on the right and 22 mm on the left (Fig 3A). The left VI nerve paresis had resolved. Intraocular pressure was 15 mmHg in the right eye and 18 mmHg in the left. Funduscopic examination of the left eye showed that venous congestion had also resolved (Fig 3B).

FIGURE 2—*Preoperative appearance of patient in July 1980, showing prolapse of the chemotic conjunctiva (A), and increased retinal congestion and hemorrhage of the left fundus (B).*

FIGURE 3—*Postoperative appearance of patient in September 1981 (A), and the left fundus which shows minimal venous congestion (B).*

DISCUSSION. Carotid-cavernous fistulae are divided into two categories: (1) those between meningeal branches of either the internal or external carotid artery and the cavernous sinus (*ie,* "dural" fistulae);[4-7] and (2) those between the internal carotid artery itself and the cavernous sinus (*ie,* "direct" fistulae). *Dural* fistulae usually arise spontaneously and appear to be due either to a preexisting arteriovenous malformation[4] or to rupture of a small dural artery into the cavernous sinus.[7] They most commonly occur in postmenopausal women.[5,6] Hemodynamically, dural fistulae generally are "low pressure, low flow" fistulae[5] and produce mild symptoms of conjunctival redness, headache, diplopia, or a bruit. *Direct* fistulae generally result from trauma which causes a tear in the cavernous segment of the internal carotid artery. A direct fistula may also result from rupture of an aneurysm involving this portion of the carotid artery. Hemodynamically, direct fistulae are "high pressure, high flow" fistulae and thus produce more striking signs and symptoms than do dural fistulae.

The blood in the cavernous sinus must drain to the heart via the jugular veins, and the symptoms depend upon the course taken by the flow.[2] In most instances venous drainage is predominantly anterior through the superior ophthalmic vein. The dilation of the arterialized orbital veins and the impairment of normal venous drainage account for the proptosis and orbital congestion. The degree of proptosis varies with the availability of venous collateral channels which can take the burden off the ophthalmic veins.[2] When the predominant drainage is posterior, through the petrosal sinuses, ocular signs may be minimal or even absent. Rarely, the predominant drainage may be through intracavernous veins, so that signs and symptoms occur in the eye opposite to the side of the fistula.

Selective internal and external carotid arteriography is required for complete evaluation of this condition. Although computed tomography will show a dilated superior ophthalmic vein, it does not show the cause of this abnormality.

Ophthalmologic abnormalities suggesting this condition include pulsating exophthalmos, an orbital or cranial bruit, arterialization of conjunctival veins, impaired eye movements, decreased vision, and glaucoma.[4] It is important to realize that a carotid-

cavernous fistula does not invariably produce pulsating exophthalmos.[3] The subjective bruit is often the most annoying symptom and can interfere with sleep. This is particularly true when the venous drainage is predominantly posterior. As with exophthalmos, conjunctival swelling is variable. Red, arterialized conjunctival veins are a consistent sign.[2,3] All three ocular motor nerves pass through the cavernous sinus and are susceptible either to direct trauma or to compression within the arterialized sinus. It is often difficult, however, to separate a nerve palsy from restriction of eye motion secondary to exophthalmos. Impaired vision has been noted in 75% to 90% of patients with carotid-cavernous fistulae, and can be either immediate, due to ocular or optic nerve injury, or delayed, as a result of chronic hypoxia of the retina.[8] Glaucoma occurs in about 35% of patients[2,3] and is usually secondary to increased episcleral venous pressure causing increased resistance to the outflow of aqueous humor from the eye.

Dural fistulae can cause diagnostic problems because of the frequent absence of characteristic signs. A bruit is reported in less than 50% of cases by many authors.[6,7] The onset is generally spontaneous and the course is characterized by remission and recurrence of mild signs and symptoms.[7] Dysthyroid eye disease, conjunctivitis, orbital tumor, and migraine have been the most frequent diagnostic errors.

Many methods have been proposed as treatment for carotid-cavernous fistulae. These range from simple compression of the carotid artery in the neck to direct repair of the fistula itself.[9] Ligation of the internal carotid artery in the neck is not an effective means of therapy for this condition as it results in a cure rate of less than 50%.[10] Because of retrograde filling of the fistula by way of the supraclinoid carotid artery, such treatment may even result in a steal of blood from the intracranial circulation, and it has been re-

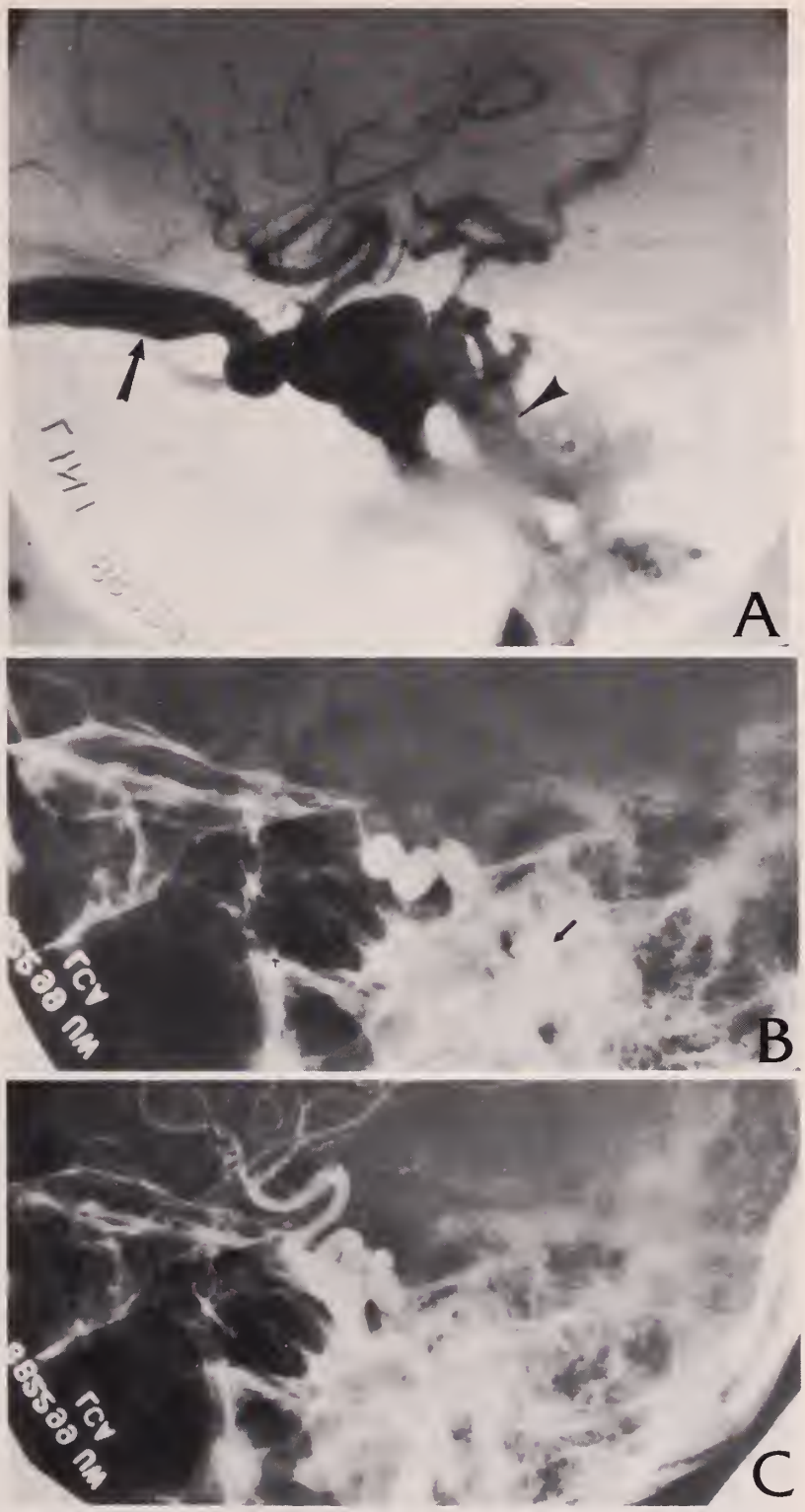

FIGURE 4—*Lateral projection of left internal carotid arteriogram (A) showing high flow, direct carotid-cavernous fistula. The cavernous sinus is opacified as is the markedly dilated superior ophthalmic vein (arrow). Posterior drainage of the fistula is into the inferior petrosal sinus (arrowhead) and jugular vein. Lateral skull film (B) after detachment of balloons. Three balloons are within the cavernous sinus and a fourth is within the inferior petrosal sinus (arrow). Lateral projection of postoperative left internal carotid arteriogram (C) showing near total occlusion of the fistula. Notice improved opacification of arteries of the left cerebral hemisphere as compared to Figure 4A, and nonfilling of the superior ophthalmic vein.*

ported to have caused death secondary to cerebral ischemia.[11]

Until recently the most effective forms of treatment have involved variations of the trapping procedure introduced by Hamby and Gardner in 1933.[10] The aim of these procedures was to isolate the abnormal communication between the internal carotid artery and cavernous sinus by occlusion of the internal carotid artery both above and below the fistula. With these methods, cure rates of 50% to 90% have been reported.[4] The major disadvantage of these forms of therapy is the sacrifice of the internal carotid artery.

Currently, the treatment of choice for a direct carotid-cavernous fistula is obliteration of the fistula through the use of detachable intravascular balloons. This treatment, originally described by Serbinenko[12] and further refined by Debrun,[13] makes it possible to obliterate the fistula while preserving blood flow through the internal carotid artery.

Dural or indirect carotid-cavernous fistulae due to communication between branches of the external carotid artery and the cavernous sinus can be easily treated by catheter embolization with a variety of materials.[4] Fistulae occurring as a result of communication between dural branches of the internal carotid artery and cavernous sinus can only be treated through a trapping procedure which isolates the segment of carotid artery from which the dural branch arises. When indicated this can also be done through the use of detachable intravascular balloons.

The indication for therapy is determined by the severity of the symptoms.[4] Dural fistulae generally cause only mild signs and symptoms, and not uncommonly will undergo spontaneous closure.[7] Therefore, in cases with mild signs and symptoms, invasive treatment is generally not necessary. Direct fistulae, however, only rarely close spontaneously, and generally produce symptoms severe enough to warrant treatment. Because such fistulae do not carry risk of an intracranial catastrophe, the potential ocular and cerebral hazards of prior forms of treatment (ligation of the internal carotid artery with craniotomy) may outweigh their advantage. Obliteration of the fistula by means of the detachable intravascular balloon technique, however, seems sufficiently risk-free to be warranted in this condition.

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ABSTRACT

Fatal *Candida* esophagitis in two diabetics after renal transplantation

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Severe necrotizing *Candida* esophagitis developed in two insulin-dependent diabetics after they received renal allografts. In each patient, the infection led to a perforation of the esophagus and was ultimately fatal despite aggressive medical and surgical management. The frequency and severity of *Candida* esophagitis seems to be higher in diabetics rather than in nondiabetic patients who receive renal transplants. In these two diabetic transplant recipients, small doses of oral nystatin did not prevent *Candida* esophagitis. Appropriate diagnostic tests must be performed promptly when symptoms of odynophagia or dysphagia develop in these patients. In diabetic transplant recipients with documented candidiasis, decreased symptoms of esophagitis should not be relied on to indicate a response to therapy. Discontinuation of immunosuppressive drugs, as well as aggressive treatment with oral and parenterally absorbed antifungal agents, offer the best hope for preventing severe morbidity or mortality from the infection in these patients. ■

Thrombocytopenia due to sulfonamide cross-sensitivity. . .

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ABSTRACT. *A 54-year-old female developed severe thrombocytopenia and hemorrhage upon re-exposure to a cross-reacting sulfonamide drug. There were no other associated conditions to account for the thrombocytopenia such as splenic sequestration or consumptive coagulopathy. Early diagnosis and supportive measures were life-saving. The course of drug-induced thrombocytopenic purpura is self-limiting if the offending drug is stopped. Only chemically unrelated agents should be substituted for a drug associated with a serious hypersensitivity reaction since cross-reactions between immunologically related agents may occur.*

IMMUNOLOGICALLY-INDUCED reactions to drugs involving platelets may result in thrombocytopenic purpura. The most common drugs reported to produce immune thrombocytopenia are quinine, quinidine, gold salts, sulfonamides and related compounds.[1] The capacity of a drug to elicit an allergic reaction is impossible to predict with certainty but some variables known to increase the risk: 1) route of administration; 2) nature of the drug; 3) nature of the host; 4) dose of the drug; 5) history of prior drug reactions; 6) degree of combination of drug metabolite (hapten) with the carrier protein which is often genetically determined; and 7) cross-sensitization.[2]

Most hypersensitivity reactions to sulfonamide drugs are against specific metabolites, thus cross reactions are uncommon. However, if the allergic response is directed against the common sulfonamide ring, then cross-sensitization may occur.

It is the purpose of this communication to present a case of recurrent immune thrombocytopenia due to the administration of structurally related sulfa compounds. Prompt recognition of an immune thrombocytopenia due to a drug and its congeners will shorten the illness and prevent serious and possibly fatal reactions.

CASE REPORT. This 54-year-old housewife was admitted to a local hospital in March 1977 because of a petechial eruption on the lower extremities and a platelet count of 46,000. Platelet estimates done as part of routine physical examinations in 1975 and again in 1976 were reported as normal. The patient had been in good health prior to 1977 except for diabetes mellitus controlled with 1.5 gm of tolbutamide daily since 1975. The patient had no prior drug allergies and she denied the use of other medications, alcohol or exposure to toxic chemicals and fumes. There was no history suggestive of a recent infection. Past surgery included an uneventful appendectomy at age 22 and a cholecystectomy at age 48. Family history included diabetes mellitus in a sibling and hypertension in her father.

The patient's symptoms began four days prior to admission. There was no history of melena, hematemesis, or hematuria. The petechial lesions were nonpruritic and localized below the knees. Physical examination was normal except for obesity and the nonblanching petechial eruption. There were no ocular or mucosal petechiae. The stool was guaiac negative. Laboratory data included a platelet count of 46,000 and a hematocrit of 44 with normal indices. The white blood cell count was 7,400 with a normal differential. Liver, kidney functions, prothrombin time and partial thromboplastin time were normal. Serum protein electrophoresis, antinuclear antibody, serum folate, B_{12} level, rheumatoid factor, CH_{50}, cryoglobulins, and cold agglutinins were negative or normal. Bone marrow aspiration and biopsy revealed increased megakaryocytes with normal granulocyte and erythroid maturation. The patient was placed at bedrest and tolbutamide was stopped. Within one week her petechial rash had cleared and by two weeks her platelet count was 136,000. Her blood sugar off tolbutamide ranged from 196 to 244 and was controlled with 22 units of NPH U-100 Insulin. At six-month followup the patient was asymptomatic with a platelet count of 228,000.

The patient remained well until the fall of 1979 when she was readmitted for melena and generalized petechiae. Her latest symptoms began 48 hours prior when hydrochlorothiazide, 50 mg per day, was started for hypertension. Upon admission the patient was hypotensive with a supine blood pressure of 94/64. The pulse rate was 128, the temperature 99.4 F. Petechial eruptions were noted on the upper and lower extremities, chest, back, and buccal mu-

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cosa. Stool was melanotic and 4+ guaiac. Her laboratory parameters revealed a platelet count of 9,000 and a hematocrit of 23. Her liver and kidney functions were again normal. Prothrombin time, partial thromboplastin time, and chest x-ray films were also normal. Treatment consisted of intravenous Solu-Medrol® (100 mg daily), six units of packed red cells and 18 platelet units to maintain her platelets above 30,000 and control her hemorrhage.

A subsequent gastrointestinal study for occult bleeding sources was negative. Repeat bone marrow examination showed increased megakaryocytes. The patient improved and by the end of the second week she was discharged with a platelet count of 52,000. After two months the patient was weaned from prednisone with platelet counts ranging from 128,000 to 178,000. A followup one year later revealed no further episodes of gastrointestinal bleeding or thrombocytopenia. Her platelet count at this time was 242,000. She wears a wrist bracelet delineating the medications to which she is allergic.

DISCUSSION. The mechanism of drug-induced thrombocytopenic purpura may be immunologic or nonimmunologic. Nonimmunologic thrombocytopenia is characterized by direct toxicity such as marrow hypoplasia or aplasia. Immune thrombocytopenia following the administration of drugs such as quinidine, chlorothiazide, acetazolamide and gold accounts for the pathogenesis of most cases of drug-induced thrombocytopenia.[2] The clinical manifestations of severe thrombocytopenia consist of easy bruisability and mucous membrane bleeding. The clinical diagnosis of immune thrombocytopenia is made on the basis of a normal or increased numbers of bone marrow megakaryocytes plus the absence of other parameters suggesting either a consumptive coagulopathy or nonimmunologic splenic sequestration. The *in-vitro* assays to confirm a diagnosis of immune thrombocytopenia such as platelet-associated IgG and complement fixation tests are technically difficult and not readily available.[3] Early recognition of the drug association can prevent life-threatening complications such as visceral hemorrhage and intracranial bleeding.

Drugs mediate decreased platelet survival by two immunologic mechanisms: 1) Gell Coombs Type II reaction in which a cytotoxic antibody is directed against a neoantigen on the platelet surface, and 2) Gell Coombs Type III reaction in which antibody-drug complexes are passively absorbed onto the platelet surface followed by either intravascular destruction or premature removal by the reticuloendothelial system.[4] The antigen in such reactions is not the intact drug but rather one of its many metabolites. Since drug metabolites due to their small molecular weight are weakly immunogenic, they must combine with a larger carrier protein to elicit an immune response. Skin testing and *in-vitro* tests with the suspected drug often do not correlate with clinical symptomotology since the true antigenic metabolite or hapten-carrier complex is unknown.

Sulfonamide drugs are among the most common agents associated with immune thrombocytopenia. A state of refractory or repeated thrombocytopenia can occur if an individual is administered a cross-reacting sulfonamide analog to which he is allergic. Cross-sensitization among all sulfonamide congeners can occur if the hypersensitivity reaction is directed against the common sulfonamide ring as opposed to the unique metabolites or side-chains. There are four classes of potentially cross-reacting sulfonamide compounds:[5,6]

1. *Diuretics:* Furosemide, thiazides, acetazolamide and related compounds.
2. *Oral hypoglycemic agents:* Sulfonylureas
3. *Antimicrobials:* Sulfa antibiotics
4. *Miscellaneous:* Diazoxide, saccharin and cyclamates, sulfanilamide and sulfadiazine. The latter two drugs may rarely cross-react with drugs that share a "benzamine" nucleus such as procaineamine since they have both a sulfonamide group plus a NH_2 group linked to the common benzene ring.

In most cases of serious drug allergy it is advisable to use agents that are structurally and chemically unrelated to the drug causing the initial adverse reaction. In this patient ethacrynic acid was safely substituted for hydrochlorothiazide.

This patient's thrombocytopenia from tolbutamide occurred after two years of innocuous use. Certain factors such as infection, fever, trauma, and azotemia may aggravate a compensated thrombocytopenia and precipitate overt bleeding.[3] It is possible that the patient had unrecognized compensated thrombocytopenia following the institution of sulfonylurea therapy, but the normal interim platelet estimates argue against this hypothesis. An alternate hypothesis is that the patient's first episode of thrombocytopenia was totally unrelated to the sulfonylurea agent, but the prompt restoration of the platelet count upon withdrawal of the drug points to a cause and effect relationship.

The patient's second administration of a sulfa analog was marked by a prompt, severe, and more prolonged depression of the platelet count characteristic of an anamnestic or recall reaction. The hemorrhage was controlled with platelet transfusions and prednisone. The mechanisms of action of the corticosteroids in reversing immune thrombocytopenia are multiple including dissociation of platelet-bound antibody, inhibition of splenic phagocytic function and an effect upon reticuloendothelial blood flow.[6,7] Prednisone, 1.0 mg per kg of body weight per day, is an accepted treatment regimen when bleeding occurs or the platelet count is less than 30,000 per cu mm. Platelet transfusions are used to

control immediate hemorrhage since corticosteroid benefits are often preceded by a variable time lag.

After an allergic drug reaction the parent or responsible guardian should be advised of the patient's sensitivity, including cross-reacting agents, drug combinations, and nonprescription drugs that might produce a similar reaction. The patient or his guardian should also be instructed to read all labels on prescriptions and nonprescription drugs. In addition, a Medic-Alert tag and the labeling of all medical records and clinic charts with the patient's drug allergy can help to avoid future reactions.

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Axillary temperatures. . .

Robert P Smith, MD, Richland Center, Wisconsin

AXILLARY TEMPERATURES are frequently used in patients' homes and in some physicians' offices. The medical literature contains little information concerning the accuracy of axillary temperatures. Therefore, a study comparing axillary and rectal temperatures in children under three years of age was conducted in my Richland Center family practice. Fifty consecutive patients under the age of three years who presented for evaluation of illness were studied. Each patient had a three-minute rectal temperature, a five-minute axillary temperature, and a ten-minute axillary temperature recorded by the same medical assistant.

The average difference between the corresponding five-minute axillary temperatures and rectal temperatures was 0.54 C. However, the five-minute axillary temperature ranged from 1.0 C above the corresponding rectal temperature to 1.9 C below the corresponding rectal temperature. This data is represented in Table 1. It is apparent that no consistent quantitative relationship between the corresponding rectal and axillary temperatures exists. However, in office practice a patient's temperature is routinely taken to determine only the presence or absence of fever.

If we use the rectal temperature as a standard and arbitrarily define febrile patients as any patient with a rectal temperature greater than 38.0 C, the following observations may be made from the table. All patients with axillary temperatures greater than 37.5 C are in the febrile group; only 4 of 32 patients with axillary temperatures less than 37.5 C are febrile. Therefore, if we use 37.5 C axillary to represent fever, we will only misclassify 4 of 50 patients. Some physicians might prefer to define febrile patients as those patients having rectal temperatures greater than 38.5 C. If we still use 37.5 C axillary to represent fever, only 4 of 50 patients also would be misclassified using this definition.

TABLE 1—*The corresponding five-minute axillary (Ax.) temperature and rectal (R.) temperatures paired in order of descending axillary temperature*

Ax.	R.	Ax.	R.	Ax.	R.
40.4	40.2	37.4	37.9	36.9	37.4
39.1	39.5	37.4	37.8	36.8	37.8
39.0	39.4	37.3	37.2	36.8	37.4
38.9	39.8	37.2	36.2	36.7	37.2
38.7	38.7	37.2	37.2	36.7	37.8
38.7	38.1	37.2	37.8	36.7	37.8
38.6	39.0	37.2	38.1	36.6	36.1
38.4	38.7	37.2	37.1	36.6	37.3
38.3	39.2	37.1	37.2	36.6	36.8
38.2	39.1	37.1	38.1	36.6	38.4
38.1	39.2	37.1	38.0	36.6	37.6
38.0	38.6	37.0	37.1	36.6	37.8
37.9	38.9	37.0	36.4	36.5	37.7
37.8	38.0	37.0	36.7	36.5	37.0
37.7	38.1			36.4	37.4
37.7	38.7			36.2	37.8
37.6	38.2			36.2	36.1
37.6	38.7			35.8	37.7

It should be noted that similar relationships exist using the ten-minute axillary temperatures. The average difference between the ten-minute axillary temperatures and the five-minute axillary temperatures was only 0.15 C. Although nursing textbooks recommend using ten-minute axillary temperatures, compliance and convenience favor the five-minute readings which appear to offer similar information.

It is almost impossible to obtain accurate oral temperatures in infants and young children, and axillary temperatures are safer and less emotionally traumatic than rectal temperatures. Since any questionable readings may always be repeated using the rectal temperature, it seems reasonable to use the axillary temperature as a screening device to detect fever in the home or office. ■

This paper is a condensation of a more detailed report of the author's study; copies of the complete set of data may be obtained upon request to the author. Reprint requests to: Robert P Smith, MD, Broadlawns Medical Center, 1800 Hickman Road, Des Moines, Iowa 50314 (phone: 515/282-2200). Copyright 1982 by the State Medical Society of Wisconsin.

Tetrahydrocannabinol (THC) for cancer patients

A review of the National Cancer Institute Program in Wisconsin

In a report prepared by the State Department of Health and Social Services, Division of Community Services, Bureau of Alcohol and Other Drug Abuse, the Controlled Substances Board evaluated the implementation of a National Cancer Institute research program in Wisconsin which distributes tetrahydrocannabinol (THC) to cancer chemotherapy patients who experience nausea and vomiting and who do not respond to conventional antiemetic drugs. The Board concluded that the distribution mechanism for THC is appropriate and adequate in Wisconsin. While THC does relieve nausea and vomiting in some cancer chemotherapy patients, adverse side effects are prevalent. Significant questions of safety and effectiveness should be resolved through scientific research and within the existing framework for testing investigational drugs that are controlled substances.

* * *

Summary. The primary concern of the Controlled Substances Board was to determine the adequacy and effectiveness of the distribution mechanism for tetrahydrocannabinol (THC). According to the survey, most pharmacists were satisfied with the mechanism because of the strict controls available. Most physicians expressed satisfaction, although there was a small group of physicians that found the restrictions cumbersome. All but one of the pharmacists and 74% of the physicians favored maintaining the current distribution program.

The Controlled Substances Board has concluded that the National Cancer Institute's distribution mechanism is adequate and effective for an investigational controlled substance of this type. Because THC is an investigational drug with a potential for abuse it should be available only to a well-defined population of patients through selected hospital pharmacies that can assure the drug's safekeeping. THC should be prescribed to informed patients who are closely monitored. THC should only be prescribed by certified cancer specialists who are associated with a research program and a certified hospital.

The Board was also interested in pharmacist and physician observations of THC safety and effectiveness. The survey results showed these perceptions closely parallel more formalized research results as reported in the scientific literature. It is apparent there is evidence that some patients' nausea and vomiting is alleviated with use of THC where conventional antiemetic drugs have failed. There are indications that THC may be more effective with some cancer chemotherapies than with others.

Adverse central nervous system side effects are prevalent, most often sleepiness, confusion, hallucinations, and poor concentration. Adverse side effects can prevent an adequate trial with THC, especially in older patients; and 12% of the physicians reported side effects that were serious enough to discontinue THC treatment altogether. Some physicians also reported additional beneficial effects of THC therapy, including antianxiety and increased appetite. Some physicians expressed a desire for broadening the program to include radiation therapy patients and larger (and smaller) dosage sizes.

The Controlled Substances Board has concluded that significant questions regarding the safety and effectiveness of THC remain. These questions should be addressed by scientific research and within the existing framework designed for the purpose of establishing safety and effectiveness prior to general product marketing of drugs for human use.

* * *

A copy of the entire review and a list of hospital pharmacists who have special use authorizations for dispensing THC are available upon request to: Dept of Health and Social Services, Controlled Substances Board, Room 434—1 West Wilson St, Madison, Wis 53702 (phone: 608/266-7586). ■

MEDICAL BRIEF

Possible Zomax® allergic reaction reported

James J Dickman II, MD
Black River Falls, Wisconsin

I WOULD LIKE TO report four cases of possible Zomax® (zomepirac sodium) allergy occurring within the last few months of middle-age females, three of whom had received prior prescriptions of Zomax® without any reaction, none of whom were on any other medication. All four had an allergic-type of reaction within 30 to 60 minutes of drug ingestion consisting of swelling lips, generalized itching, tightness across the chest, difficulty breathing, and an erythematous rash. All responded to Adrenalin® (epinephrine) and Benadryl® (diphenhydramine). Two patients had no other known allergies. One patient had a history of penicillin allergy, and the third patient had a history of allergy or adverse reaction to penicillin, aspirin, Valium® (diazepam), Novocain® (procaine), and Flexeril® (cyclobenzaprine). Some caution might be used in the use of this drug.

* * *

Editor's note: The package insert with Zomax® indicates that urticaria has been reported with an incidence of less than 1% and that the causal relationship is "probable." ■

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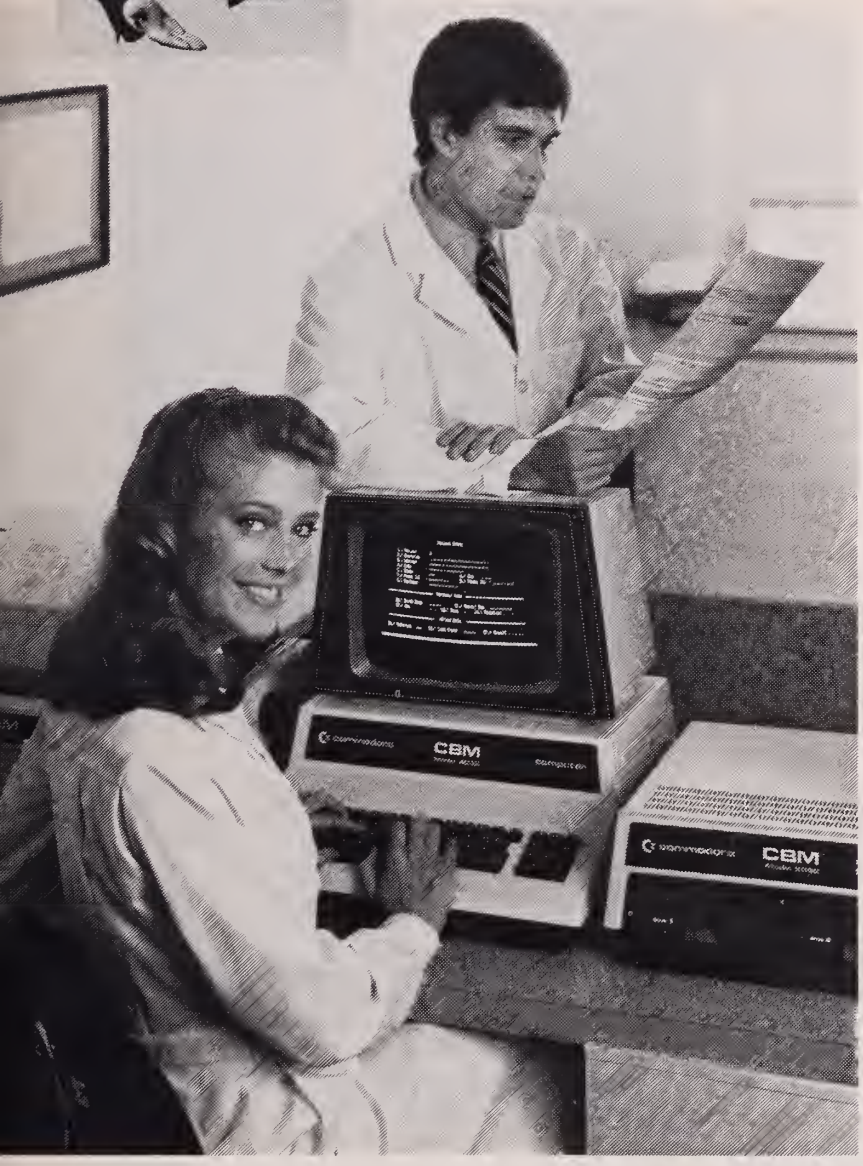

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THE NEW PRESIDENT

Gerald C Kempthorne, MD

GERALD C KEMPTHORNE, MD, a Spring Green family physician, became the State Medical Society's 127th president May 14 during the Society's Annual Meeting in Milwaukee. Doctor Kempthorne, 51, succeeds Albert J Motzel Jr, MD, Waukesha, as head of the 5200-member organization.

A native of Platteville, Doctor Kempthorne graduated from Dodgeville High School, then served in the United States Navy from 1951 to 1954. He graduated from the University of Wisconsin in 1956 with a Bachelor of Science degree. He received a Master of Science degree from Kansas State University in 1957. He subsequently graduated from the University of Maryland School of Medicine and served his internship at Cook County Hospital, Chicago, 1961-62.

Doctor Kempthorne has maintained a private practice in the Spring Green community for 20 years. He is a past president and past secretary of the medical staff of Sauk Prairie Memorial Hospital and serves as medical director of the Black Earth Manor Nursing Home in Black Earth and the Greenway Manor Nursing Home in Spring Green. In 1981 he was named "Physician of the Year" by the Wisconsin Association of Nursing Homes.

Doctor Kempthorne has held several posts in organized medicine at state and county levels, as well as being a spokesman for the Wisconsin medical community at national events.

As chairman of the Society's Commission on Mediation and Peer Review, Doctor Kempthorne has been a major participant in establishing a comprehensive statewide program for helping physicians impaired by alcohol, other drugs, or emotional and physical disorders. He has chaired the Commission's Impaired Physician Program since its inception in 1977. He also serves as cochairman of the Coordinating Council for the Statewide Impaired Physician Program, a joint effort of the State Medical Society of Wisconsin and the State Medical Examining Board.

Doctor Kempthorne has served on the Wisconsin Political Action Committee (WISPAC) Board of Directors, SMS Committee on Federal Legislation, SMS Mental Health Committee, and Advisory Committee on Community Program Standards for the State Department of Health and Social Services.

A past president and past secretary of the Sauk County Medical Society, Doctor Kempthorne also served as a councilor of the State Medical Society from 1979 to 1981 when he was named president-elect. He is a member and currently chairman of the Medicaid Medical Audit Committee of the State Medical Society. This year he was appointed to the Physician Assistant Program Advisory Committee to the University of Wisconsin-Madison.

In addition to his state and county medical society involvements, Doctor Kempthorne is a fellow of the American Academy of Family Physicians, a diplomate of the National Board of Medical Examiners (1962), and was certified in 1974 by the American Board of Family Practice and recertified in 1981. He also is a member of the American Medical Association, American Geriatrics Society, and the Academy of Psychosomatic Medicine.

The new president also is actively involved in community affairs. He is a past president of the River Valley School Board of Education, a past president and member of the Spring Green Lions Club, a member of the local Chamber of Commerce, and a former president of the Sauk County Republican Party.

In 1980 Doctor Kempthorne became a member of the Board of Directors of the American Players Theatre, a national (Shakespeare) theatre center for the classics in Spring Green. Furthermore, he has served on the boards of Valley Studio, the Uplands Arts Council, and the Spring Green Theatre Corporation.

Doctor Kempthorne and his wife, Miep, have two sons. ■

Dr Chesley Erwin to head Society next year

Chesley P Erwin MD, Milwaukee, was elected president-elect of the State Medical Society of Wisconsin May 14 at its Annual Meeting in Milwaukee.

Doctor Erwin, a pathologist, is medical examiner for Milwaukee County and is a professor of pathology at the Medical College of Wisconsin. He is a former president of the Medical Society of Milwaukee County and the Wisconsin Society of Pathologists as well as a member and past president of the Milwaukee Academy of Medicine.

Currently he is a member of the State Medical Society Board of Directors and from 1981-82 served as vice-speaker of its House of Delegates, the Society's chief policy-making body.

The new president-elect is a graduate of the University of Oklahoma School of Medicine, interned at Harris Hospital, Fort Worth, Texas and served a residency in pathology at Milwaukee County General Hospital.

He is Board certified in anatomic and clinical pathology and in forensic pathology, and is a fellow of the College of American Pathologists, the American Society of Clinical Pathologists, and the American Academy of Forensic Sciences.

In other elections at the Society's House of Delegates session, John J Foley, MD, Menomonee Falls, was elected treasurer and Vernon M Griffen, MD, Mauston, was elected vice-speaker of the House of Delegates.

Physicians reelected to serve as delegates to the American Medical Association for 1983-84 are: John K Scott, MD, Madison; Patricia J Stuff, MD, Bonduel; and DeLore Williams, MD, Milwaukee. Alternate delegates reelected for 1983-84 are: Cornelius A Natoli, MD, La Crosse; John D Riesch, MD, Menomonee Falls, and Walter J Woloschek, MD, Wauwatosa.

The Society also confirmed the reelections of the following physicians to its Board of Directors: John P Mullooly, MD, Milwaukee; Jerome W Fons Jr, MD, Cudahy; J D Kabler, MD, Madison; Cyril M Hetsko, MD, Madison; James J Tydrich, MD, Richland Center; Allen O Tuftee, MD, Beloit; Jung K Park, MD, Wisconsin Rapids; Darold A Treffert, MD, Fond du Lac, and Irvin L Schroeder, MD, Plymouth.

The SMS House of Delegates during the two-day meeting:

•Went on record as being in favor of no allowable blood alcohol level in any driver on Wisconsin highways. Under current law, intoxication is defined as a blood-alcohol level of 0.10% or 100 milligrams of alcohol per 100 milliliters of blood.

•Will seek legislation to raise the legal drinking age in Wisconsin to 21.

•Reaffirmed its intent to seek reenactment of a motorcycle helmet law in Wisconsin.

•Opposed efforts to make existing employment relationships illegal between physical therapists and physicians. The House noted that a recent opinion of the Wisconsin Attorney General has upheld the right of physical therapists to be employed by physicians. The House said employment relationships between PTs and physicians have historically operated to protect patients by providing them with high quality care as prescribed and monitored by physicians.

•Encouraged the formation of liaisons at the state and county levels between medicine and business and industry, including representatives of both employees and employers. Furthermore, the House said that these medicine-business coalitions should involve county and state cost containment committees in their work.

•Urged all practicing physicians to repay loans they received during the course of their medical training.

•Called for physicians and public representatives at state, national, and international levels to take whatever "carefully considered steps necessary" to reduce the

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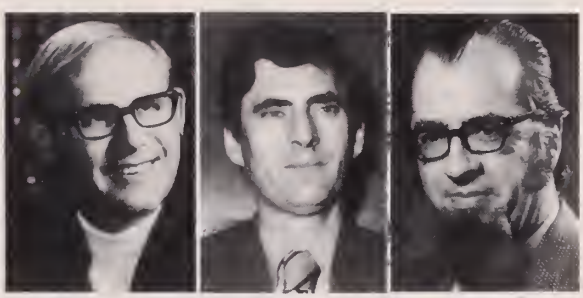

Doctor Treffert Doctor Foley Doctor Erwin

SMS Board elects officers

Darold A Treffert, MD, Fond du Lac, was reelected chairman of the Board of Directors of the State Medical Society of Wisconsin May 15 during the Society's Annual Meeting in Milwaukee.

The Board reelected Timothy T Flaherty, MD, Neenah, vice chairman; and Richard W Edwards, MD, Richland Center; E J Nordby, MD, Madison; A A Quisling, MD, Madison, and H Kent Tenney, MD, Madison, assistant treasurers. Earl R Thayer was reelected secretary and general manager.

Reelected to serve as editorial director of the *Wisconsin Medical Journal* was Wayne J Boulanger, MD, Milwaukee. Editorial Associates appointed for 1982 are John P Mullooly, MD, Milwaukee; Raymond A McCormick, MD, DePere; Victor S Falk, MD, Edgerton, and Russell F Lewis, MD, Marshfield. ■

likelihood of nuclear weapon explosions. The House also encouraged the efforts to provide reliable scientific information to the profession and the public regarding the medical consequences of nuclear weapon explosions.

•Directed the State Medical Society to write policy guidelines on artificial insemination. The resolution noted that nationwide attention had focused on Wisconsin as a result of a Milwaukee physician having artificially inseminated an unwed female who then applied for welfare benefits.

•Supported S 1929, the "Comprehensive Smoking Prevention Education Act," and recommended that it be amended to require the elimination of all federal tobacco subsidies. The bill would require the Secretary of Health and Human Services to execute a public education program on the health dangers of cigarette smoking, and would require stronger health warnings on cigarette packages and advertisements.

•Directed the Society to seek repeal of the second surgical opinion program for Medicaid patients in Wisconsin.

•Referred to the Society's Committee on Medical Liability two resolutions asking that the Society seek legislation restricting lawyer's fees in malpractice cases. One resolution asked that contingency fees for lawyers in malpractice cases not be allowed to exceed more than twice their usual charges. Another resolution asked that a judge approve any contingency fee arrangement before a case could proceed and that a client's inability to pay normal legal fees be proved before any contingency fee arrangement is allowed.

•Endorsed HR 4554 which proposes repeal of the Federal Health Planning Act. The House directed the Society to encourage the Governor to abandon the current health planning system in Wisconsin in favor of a local voluntary health planning system that included adequate physician input and participation.

•Reaffirmed its support of the intent and provisions of the "Clean Indoor Air Act" which would regulate smoking in public places.

•Directed the Society to undertake programs to inform Wisconsin physicians, employers, and citizens that health insurance policies in which the insurer determines what is "usual, customary, and reasonable" (UCR) charges are not necessarily "total" coverage policies. Furthermore, the Society was directed to inform all affected parties of the various avenues of recourse.

•Authorized proceeding with an injunction against the State of Wisconsin to halt implementation of Medicaid regulations requiring virtually all psychiatric services under Medicaid be authorized by a 51.42 board. ■

CES FOUNDATION

CONTRIBUTIONS—APRIL 1982

The Charitable, Educational and Scientific Foundation of the State Medical Society is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for April 1982.

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SMS Members—*Voluntary Contributions*

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Charles L Steidinger, MD; Richard E Jensen, MD; Morris Siegel, MD; Hartland Clinic; Meadowood Family Physicians; Monona Grove Clinic; Elmbrook Memorial Hospital; Wausau Insurance Company; MT Morrison, MD; Allen Tabor, MD; RM Nesemann, MD—*Summer Student Externship Program*

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Memorials

Mr-Mrs Earl R Thayer—*Ralph Frank, MD; Lindley Sprague, MD (Museum of Medical Progress Endowment Fund)*

Marathon County Medical Society Auxiliary—*Florence Boslough (Marathon County Auxiliary Loan Fund)*

Dr-Mrs Robert T Schmidt—*Mrs Alvin Brusky; Dr Gerald Mortell; Mrs Joyce Rosenberg; Mrs Anita McDonald (Brown County Student Loan Fund)*

Dr-Mrs Robert J Schmidt, Jr—*Mrs Alvin Brusky (Brown County Student Loan Fund)*

Dr-Mrs Farrell F Golden—*Florence Holmgren*

Robert M Railey, MD—*Charles Shields, MD* ■

SMS names new field consultant

The State Medical Society recently named Susan McHugh as field consultant to the Physicians Alliance District 1. Susan worked for the Medical Society of Milwaukee County from 1979 to 1980. She will be assisting SMS Physicians Alliance field consultant Lois Riley in staffing the District 1 counties of Milwaukee, Ozaukee, Washington, Waukesha, Walworth, Racine, and Kenosha. The PA field staff is now at full strength with six consultants.

Susan can be reached at 4475 West Dean Road, Apt 203, Milwaukee, Wis 53223 (phone: 414/355-5262) or call the MSMC office at 414/271-4328.

The PA field consultant for District 4, Paul Jacobson, has a new address and telephone numbers: 7710 Blue Valley Drive, Eau Claire, Wis 54701 (phone: 715/874-6125) or answering service: 715/835-1753. ■

Obituaries

Lindley Vincent Sprague, MD, 81, Middleton, died Mar 26, 1982 in Madison. Born Apr 7, 1900 in Basil, Ohio, Doctor Sprague graduated from Detroit College of Medicine and Surgery in 1923 and completed his internship and residency at the City of Detroit Receiving Hospital. He had been in general practice in Madison from 1926 until his retirement in 1977. Doctor Sprague taught part-time at the University of Wisconsin Medical School, Madison, from 1926 until his retiring in 1970 as an Emeritus Professor. He served as secretary, vice president, and president of the Dane County Medical Society in 1932, 1933, and 1934. He had been on the medical staff of St Mary's Hospital, Madison, and had served as president of the medical staff in 1935, 1953, and 1955. He was a member of the American College of Obstetrics and Gynecology. Doctor Sprague was a member of the "50 Year Club" of the State Medical Society of Wisconsin, and also was a member of the American Medical Association. Surviving are his widow, Virginia, and a son, Dr William L of Whittier, Calif.

James Richard Hoon, MD, 66, Sheboygan, died Mar 28, 1982 in Sheboygan. Born Mar 26, 1916 in Monongahela, Pa, Doctor Hoon graduated from the University of Pittsburgh Medical School in 1940, and served his internship at Mercy Hospital in Pittsburgh. His residency was completed at the Mayo Clinic in Rochester, Minn. He served in the United States Army Medical Corps from 1941-1946. He was on the medical staff of the Sheboygan Clinic from 1951 until his retirement in 1981 and he also served on the medical staff at Sheboygan Memorial and St Nicholas hospitals in Sheboygan. Certified by the American Board of Surgery, he was a fellow of the International College of Surgeons, the American College of Gastroenterology, and the American College of Surgeons. A member of the State Medical Society of Wisconsin, Doctor Hoon had served many years on the Committee on Cancer of the Society. He also was a member of the Sheboygan County Medical Society, American Medical Association, American Association of Railway Surgeons, American Geriatrics Society, American Association of Advancement of Science, and the American Cancer Society, serving as president of the Wisconsin Division in 1968. Surviving are four sons, Michael J, Washington, DC; Anthony J, Appleton; David R, Madison, and Gregory T of Sheboygan; and four daughters, Mrs Michael (Patricia) Tansey, Arlington, Tex; Mrs Ira (Christine) Altshuler, Madison; Capt Rosemary Hoon, Cheyenne, Wyo, and Lisa V Hoon of Madison.

Edward James O'Brien, MD, 55, Whitefish Bay, died Apr 6, 1982 in Milwaukee. Born Apr 3, 1927 in Milwaukee, Doctor O'Brien graduated from Marquette University School of Medicine in 1953 and served his internship and residency at St Joseph's Hospital in Milwaukee. Doctor O'Brien served in the United States Army from 1945-1946. He was a member of the American Academy of Obstetricians and Gynecologists, member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association. Surviving are his widow, Annette; two daughters, Mary Ellen and Bridget Marek; and a son, Timothy.

Conrad W Giesen, MD, 73, Superior, died Apr 7, 1982 in Rochester, Minn. Born Mar 10, 1909 in Superior, Doctor Giesen graduated from Rush Medical College, Chicago, Ill, and served his internship at Ancker Hospital in St Paul. His residency was completed at Minneapolis General Hospital. Doctor Giesen began his medical practice in 1939 and was active in the Giesen Clinic until his death. He was on the medical staff of St Mary's Hospital and had served as president of the staff and also as president of the Douglas County Medical Society. He was preceded in death by his father, Charles W Giesen, MD, Superior, and his brother Charles P Giesen, MD of Tomah. He was a member of the State Medical Society of Wisconsin and the American Medical Association. Surviving are his widow, Mary Jane; three sons, Dr Philip, Kalamazoo, Mich; Brian and Thomas, both of Superior; and two daughters, Mrs Kenneth (Mary Joan) Kaufhold, North St Paul, Minn, and Kathy of St Paul, Minn.

Vitoldas S Balciunas, MD, 62, Kenosha, died Apr 17, 1982 in Kenosha. Born Oct 5, 1919 in Lithuania, Doctor Balciunas graduated from the Zurich Switzerland Medical School and served his internship at Milwaukee County Hospital. His residency was completed at Columbus and Cook County hospitals. Doctor Balciunas had practiced in Kenosha since 1963. He was a member of the Kenosha County Medical Society, State Medical Society of Wisconsin, and the American Medical Association. Surviving are his widow; a son, Vitoldas, and two daughters, Birute and Aldona all at home.

Isadore B Reifenrath, MD, 90, Wauwatosa, died Apr 19, 1982 in Wauwatosa. Born Nov 27, 1891 in Cedar County, Neb, Doctor Reifenrath graduated from Marquette University School of Medicine in 1922 and served his internship at Milwaukee County Hospital. Doctor Reifenrath had practiced medicine in Milwaukee since 1925 and was an honorary member of Elm Brook Hospital medical staff and had also served as chief-of-staff at Misericordia Hospital. He became a member of the "50 Year Club" of the State Medical Society of Wisconsin in 1972, was a member of The Medical Society of Milwaukee County, and a member of the American Medical Association. Surviving are a daughter, Mrs Jeanne Craite, Wauwatosa; two sons, John, Rochester, NY, and Dr William of Elm Grove. ■

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Once pain and inflammation subside, for dual action recommend regular ANUSOL®—to maintain patient comfort—and TUCKS®—to maintain patient anorectal hygiene.

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**Meeting of Am Soc Colon / Rectal Surgeons, May 1980.*
***Based on total prescriptions filled for hemorrhoidal preparations during the first three quarters of 1981. The National Prescription Audit, IMS America Ltd, Sept 1981.*
†1981 data from leading marketing research organization.

PD-85-JA-0867-P-1 (2-82)

ANUSOL-HC® Suppositories/ ANUSOL-HC® Cream

Before prescribing, please see full prescribing information. A Brief Summary follows:

Indications and Usage: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain, itching and discomfort in external and internal hemorrhoids, proctitis, papillitis, cryptitis, and fissures, incomplete fistulas, pruritus ani and relief of local pain and discomfort following anorectal surgery.

Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol® Suppositories or Ointment.

CONTRAINDICATIONS

Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.

WARNINGS

The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.

PRECAUTIONS

General

Symptomatic relief should not delay definitive diagnoses or treatment.

Prolonged or excessive use of corticosteroids might produce systemic effects.

If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.

In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.

Anusol-HC is not for ophthalmic use.

Pregnancy

See "WARNINGS"

Pediatric Use

Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.

DOSAGE AND ADMINISTRATION

Anusol-HC Suppositories—Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at bedtime for 3 to 6 days or until inflammation subsides. Then maintain comfort with regular Anusol Suppositories.

Anusol-HC Cream—Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain comfort with regular Anusol Ointment.

NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.

Store between 59°-86°F (15°-30°C)

1089G010

Physician Briefs

*Physician members of State Medical Society of Wisconsin

Marc Tumerman, MD, Springfield, Ill, will begin his medical practice at the Prairie View Family Practice Medical Center in Sun Prairie in July. Doctor Tumerman is a graduate of the Southern Illinois University School of Medicine and is completing his family practice residency at St John's Hospital in Springfield. He will be joining Janis Bird, MD at the Center.

James T Grosshans, MD, Wautoma, recently became associated with Edward Glazier, MD.*A Chicago native, Doctor Grosshans graduated from the University of Illinois Medical College and served in the United States Army Medical Corps. He had previously practiced, since 1975, in York, Ala. Doctor Grosshans also is a member of the medical staff of Wautoma Memorial Community Hospital.

Terrence L Meece, MD,* a graduate of the University of Illinois Abraham Lincoln Medical School, Chicago, has joined the Fox Valley Residency Clinic, Appleton, as associate director. Doctor Meece has done postdoctoral work at Michigan State University, Office of Medical Education, Research and Development, Family Practice Faculty Development, and served his residency in Midland Hospital Center, Michigan. Doctor Meece earned the Harry A Towsley Award for outstanding performance as a resident in 1978 and is Board certified. In addition to his administrative duties, Doctor Meece will serve as an instructor and also will have a part-time private practice.

Richard M Reich, MD, Madison, recently joined the Jackson Clinic East. Doctor Reich graduated from Cornell University Medical College, New York, and completed his internship and residency in internal medicine as well as a fellowship in infectious diseases, at the University of Wisconsin Hospital & Clinics, Madison. He also completed a fellowship in geriatrics at the Wm S Middleton Veterans Administration Hospital. He is a member of the American College of Physicians, American Medical Joggers Association, American Society of Microbiology, and American College of Sports Medicine.

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Stephen J Delventhal, MD, recently joined the medical staff of the Krohn Clinic in Black River Falls. Doctor Delventhal graduated from New Jersey Medical School and served his residency in surgery at University of Wisconsin Hospitals and Clinics in Madison. He had previously practiced at Beloit Memorial Hospital and at Clinich Valley Memorial Hospital in Richlands, Va. Doctor Delventhal also was a medical volunteer in the Republic of Cameroon, West Africa, for four months.

Harold E Manhart, MD* Madison, a member of Madison Ear, Nose and Throat Associates , will provide his services to the Memorial Hospital, Dodgeville, on a once-a-month basis. Doctor Manhart graduated from Ohio State University Medical School and served his residency at University Hospital and Clinics in Madison. A G Anderson, MD, will join the ENT Associates in July and will rotate schedules with Doctor Manhart.

William M Hebble, MD,* Beloit, recently was the host of the annual meeting of the Great Lakes Orthopedic Travel Club. Orthopedic surgeons from several states attended the meeting. Doctor Hebble arranged the two-day program which was held to help members keep pace with the "exploding technology and knowledge" of the field of orthopedics.

William C Fetherston, MD,* Fox Point, recently was named president of the medical staff at St Mary's Hospital in Milwaukee. Doctor Fetherston is chairman of the hospital's Department of Obstetrics and Gynecology and succeeds George E Collentine, MD,* Whitefish Bay. John C Linn, MD,* Shorewood, was named secretary-treasurer.

David A Satchell, MD, Manitowoc, recently was a soloist at the Manitowoc Symphony Orchestra's concert. A bassoonist, Doctor Satchell played a concerto in A minor by Vivaldi and a Hungarian rondo by Weber. Doctor Satchell, a native of Saginaw, Mich, began playing the bassoon at age 16 and played in the University of Michigan's Symphonic Wind Ensemble. A surgeon, Doctor Satchell completed his residency training in Seattle, WA, and has practiced in Manitowoc since 1976. ■

IF YOU WISH TO HELP AN IMPAIRED PHYSICIAN

The State Medical Society of Wisconsin's Impaired Physician Program wishes to identify, intervene, and bring about the rehabilitation of physicians impaired by use of alcohol and other drugs, or mental or physical infirmity. Persons may call 608/257-6781 or toll-free: 800/362-9080 and explain their concern to Mr John LaBissoniere or Mr H B Maroney of the Impaired Physician program staff. The caller's identity will be kept in complete confidence. ■

AMA Physician's Recognition Award Recipients

LISTED BELOW are those physicians in Wisconsin who have earned the AMA Physician's Recognition Award in recent months. The award was established in 1969 "to recognize, encourage and support physicians who participate regularly in continuing medical education and to emphasize the importance of developing more meaningful continuing medical education opportunities for physicians." A minimum of 150 credit hours of CME must be earned over a three-year period to qualify for the award. The hours may include such activities as conferences, residencies, teaching, writing, private reading, listening to cassettes, home study courses, consultation, and peer review; at least 60 of the hours, however, must be from formal CME programs sponsored or cosponsored by organizations accredited for these activities. The State Medical Society of Wisconsin congratulates the following physicians who have distinguished themselves and their profession by their commitment to continuing education:

APRIL 1982

*Algan, Ahmet Mitat, Loyal
*Behling, Ronald E, Madison
*Behrens, Susan F, Beloit
*Biros, Dennis G, La Crosse
*Boedecker, Robert A, Hales Corners
*Bugarin, Nunilo L, Tomahawk
Bush, Robert K, Madison
*Claybaugh, William M, Milwuakee
*Cusick, Joseph F, Milwaukee
*De Arteaga, Julio C, Brillion
*Doyle, Thomas J, Superior
*Doyle Jr, Thomas J, Eau Claire
*Edland, Robert W, La Crosse
Eichelman, Burr S, Madison
*Engstrom, Denton P, Appleton
*Felton, Owen L, Neenah
*Francisco, Orlando M, Tomahawk
*Gambert, Steven R, Wood
*Hamp, James A, Ashland
*Haskell, David S, Milwaukee
*Heggestad, Kay A, Madison
*Hoftiezer, James W, Manitowoc
*Jackson, Edgar B, Milwaukee
Jefferson, James W, Madison
*Kim, You-Sah, Phelps
*Kindschi, George W, Monroe
*Kobelt, Carl C, Manitowoc
*Koppa, John F, Madison
*Koschmann, Edgar B, Wausau
*Kutter, Ursula A, Milwaukee
*Larson, Sanford J, Milwaukee
*Madden, William J, Racine
*Martinetti, Dominic J, Hurley
*Meyer, Glenn A, Milwaukee
*Mockert Jr, Thomas, Sheboygan
*Perry, Thomas K, Manitowoc
Rakow, Robert W, Mequon
Rasansky, Marc, Milwaukee
*Roth, Donald A, Brookfield
*Rudy, Warren B, Wausau
*Sackett, Joseph F, Madison
Sanfelippo, Michael, Milwaukee
*Shahbandar, Hassan, Appleton
*Steiger, Frederic A, Cedarburg
*Taylor, Geoffrey, Wausau
*Tsuchiya, Goro, Racine
*Watts, Alice D, Oregon
*Wepfer, Joseph F, Wauwatosa
*Winters, John C, Milwaukee
*Wolkomir, Michael S, Milwaukee ■

Members of the State Medical Society of Wisconsin

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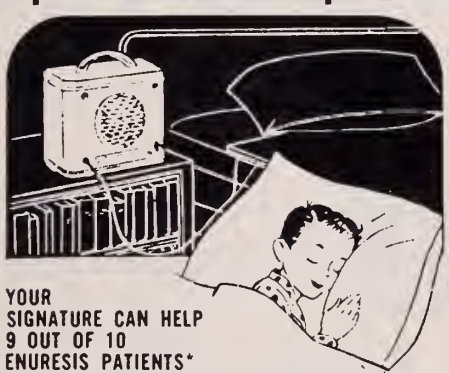

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Milwaukee Gynecological Society recently installed Roland Pattillo, MD, as its new president. Doctor Pattillo is Professor of Gynecology at the Medical College of Wisconsin, Milwaukee. Other MDs elected to office are William J Buggy, MD,* Wauwatosa, president-elect, and Michael T Jaekels, MD,* Milwaukee, secretary-treasurer. Members of the Board of Governors are MDs Stanley A Korducki;* Jay A Larkey;* and Walter R Schwartz,* all of Milwaukee.

Wisconsin-Upper Michigan Society of Ophthalmology is now planning its 1982 Annual Meeting which will be held in Marshfield, Saturday, September 18, with the scientific session to be held at the Marshfield Clinic. Accommodations will be arranged at the Holiday Inn, Marshfield.

Charles A Errico, MD,* president, of Marshfield has announced that the scientific program will include presentations by Richard G Chenoweth, MD of Portland, Oregon, a vitreoretinal specialist, who will discuss "Vitreoretinal Problems for the General Ophthalmologist;" and William M Bourne, MD of the Mayo Clinic, Rochester, Minnesota, a specialist in corneal and external diseases. Other participants will be announced when the program is completed.

Interested ophthalmologists who are not now members may obtain further information regarding meeting plans and membership by writing or calling Michael R McCormick, MD,* Secretary-Treasurer, 102 East Main St, Waukesha, Wis 53186 (414/547-3352).

Milwaukee Ophthalmological Society officers for the year 1982-83 have been announced as follows: president—Gerald W Wadina, MD,* Cudahy; vice president—Ernest L MacVicar Jr, MD,* Racine; secretary—Michael R McCormick, MD,* Waukesha; and treasurer—Robert A Hyndiuk, MD,* Milwaukee.

President Wadina has announced that, following the summer hiatus, the next meeting of the Society will be held Wednesday, October 20, at the University Club in Milwaukee. This is slightly in advance of the usual meeting date, but it was rescheduled because many ophthalmologists will be attending the International Meeting in conjunction with the Annual Meeting of the American Academy of Ophthalmology in San Francisco at that time.

Further information regarding program, meeting dates, or membership may be obtained by contacting Michael R McCormick, MD, Secretary, 102 East Main St, Waukesha 53186 (414/547-3352). ■

National Association of Residents and Interns (NARI) has expanded its loan program which substantially increases the loan amounts available through its popular Senior Medical Student, In-Training, Going-Into-Practice, and Established Practitioner Loan Plans.

"The policy of continuing to offer financing at a time when other sources, including banks and lending institutions, are cutting back is nothing new to NARI," says Dennis Freeman, NARI Loan Program Coordinator. "More than 7,000 doctors in training and in practice applied for over $85 million last year alone; and now that we've increased the amounts available to members of the medical and dental professions, we expect an even greater response this year," Freeman notes.

"For more than 15 years now, NARI has been meeting doctors' growing financial needs," Freeman adds. "We continue to offer the flexible repayment schedules and highly competitive rates that doctors want."

The higher loan amounts offered through the NARI Loan Program are as follows:

Senior Medical Student Loan Plan: (1) Up to $5,000 [increased from $3,000] for senior students. (2) Up to $8,000 [increased from $5,000] for "matched" senior students.

In-Training Loan Plan—for Interns, Residents, Fellows: (1) Up to $8,000 [previously $5,000] during the first year of training. (2) Up to $12,000 [previously $7,500] during the second year of training. (3) Up to $15,000 [previously $10,000] during the third year of training and beyond.

Going-Into-Practice Loan Plan: (1) Up to $25,000 [increased from $20,000] for those entering practice in 90 days or less, and those newly in practice.

Established Practitioner Loan Plan: (1) Up to $40,000 [formerly $35,000] for those in practice for one year or longer. ■

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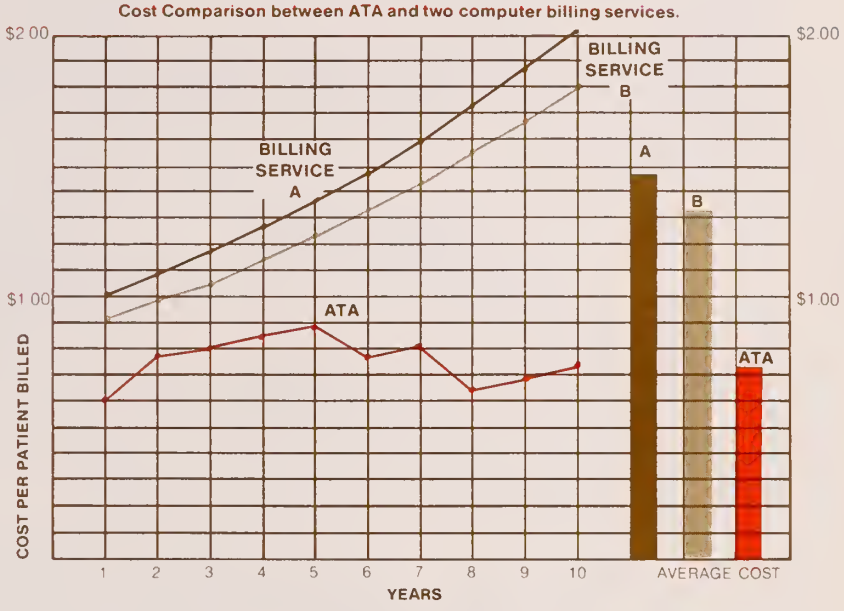

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Medical computer systems

Fox Valley Residency Clinic, Appleton, one of six in the state, is beginning its third year of operation and six physicians have been selected and named by Charles E Fenlon, MD,* director. Accepted for their first year of the three-year program are MDs Lawrence R Donatelle, a graduate of the University of North Dakota School of Medicine, Fargo; Alan Halsey and Brian D Harrison, both of the Mayo Medical School, Rochester, Minn; James M Quayle, Upper Peninsula Medical Education Program, Michigan State University College of Human Medicine, Escanaba; Gregory L Gill, University of Wisconsin Medical School, Madison, and Paul M Shattuck, Indiana University School of Medicine, Indianapolis. This is the third class that has been admitted to the residency clinic program which is under the auspices of the University of Wisconsin Medical School.

Holy Family Hospital, Manitowoc, in conjunction with the Milwaukee chapter of the American Heart Association and Mid American Medical Services, recently sponsored an "Advanced Cardiac Life Support" course. The course involved lectures, demonstration and practice in criteria set forth in handling heart attack victims. Physicians who successfully completed the course received a certificate indicating they had met revised AHA standards. They are MDs Norman C Schroeder,* Mary A Govier,* Robert L Dernlan,* Kenneth Hartenian, Mark A Sager,* Barry V Bast,* Thomas R Rauschenberger,* Franz Kraler, Richard Mansfield, Elwood Robins, Leonardo Aponte, Steven D Driggers,* E Douglas Gat, and Donald J DeBruyn.*

The Faye McBeath Foundation has awarded the Medical College of Wisconsin (MCW) a $50,000 grant to support the building of the General Clinical Research Center (GCRC) at Froedtert Memorial Lutheran Hospital (FMLH). The new research facility is needed in order for MCW to continue receiving $500,000 in annual research grants from the Division of Research Resources of the National Institutes of Health, to support the activities of the GCRC. The College is celebrating the 20th anniversary of GCRC unit which is currently located at Milwaukee County Medical Complex. The new facility at FMLH is expected to be ready in one year. Leonard W Cronkhite Jr, MD, MCW president, reported that the MCW faculty working in the GCRC have made significant contributions to the development of current treatment of a variety of disorders including diabetes, obesity, hypertension, low blood pressure, atherosclerosis, heartburn, kidney stones, and diseases of the stomach and lungs. ■

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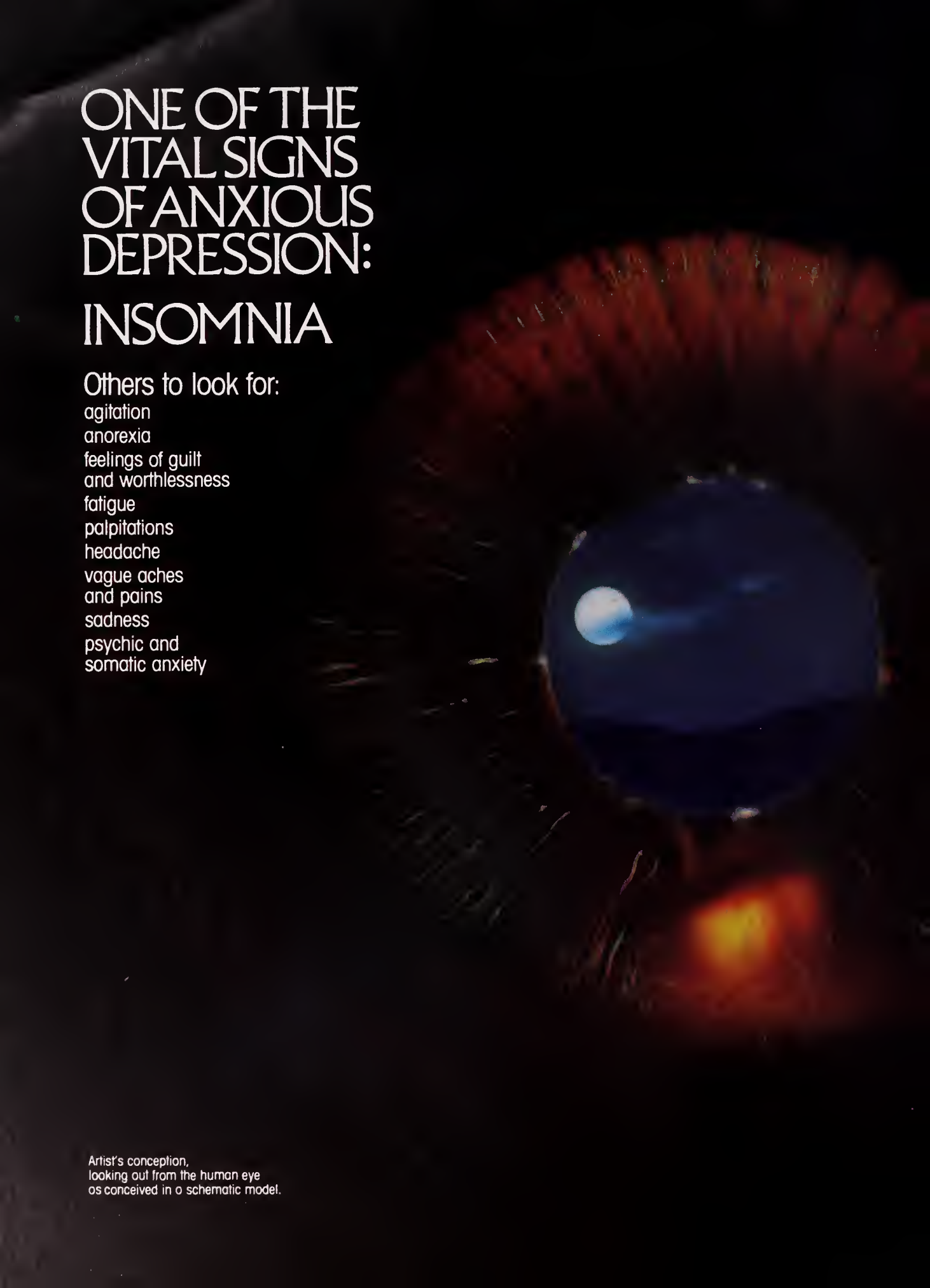

Artist's conception,
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in moderate depression and anxiety

Limbitrol® IV

Tablets 5-12.5 each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)
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Specific therapy with h.s. dosage convenience

Please see summary of complete product information on following page.

LIMBITROL® TABLETS Tranquilizer—Antidepressant
Before prescribing, please consult complete product information, a summary of which follows:
Indications: Relief of moderate to severe depression associated with moderate to severe anxiety
Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use; then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.
Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).
Usage in Pregnancy: **Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).
Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.
Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.
The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:
Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.
Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.
Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.
Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.
Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.
Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.
Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.
Endocrine: Testicular swelling and gynecomastia in the male; breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels.
Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.
Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.
Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly. Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased to six tablets or decreased to two tablets daily as required. Limbitrol 5-12.5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses.
How Supplied: White, film-coated tablets, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt) – bottles of 100 and 500, Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10, Prescription Paks of 50.

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RATES: 40¢ per word, with a minimum charge of $16.00 per ad. BOXED AD RATES: $32.00 per column inch. DEADLINE: Copy must be received by the 20th of the month preceding month of issue; e.g., copy for the August issue is due July 20. Send copy to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 800/362-9080.

Physicians Exchange

La Crosse—Dynamic 52-physician multispecialty clinic is recruiting in the following specialties: **Vascular Surgery, Neurology, Hematology/Oncology, Family Practice.** Strong in primary and secondary care, we have four active satellite clinics. Modern 350-bed hospital, with CT scanner and medical staff of 92 MDs including neurosurgeon, immediately adjacent to clinic building. La Crosse is a progressive, family oriented city of 50,000 in the beautiful Mississippi River Valley with a medical referral area of greater than 150,000. Exceptional cultural, educational and recreational opportunities locally. Contact: P S Shultz, MD, Medical Director, Skemp-Grandview-La Crosse Clinic, 815 S 10th St, La Crosse, WI 54601; ph 608/782-9760. 5-7/82

Family Practice Physician/or Primary Care Oriented Internist to join two family practice physicians and a Board certified surgeon in a group practice. Located in a community of 2,500 in southwest Minnesota. This medical clinic is supported by a modern 30-bed acute care hospital and 138-bed skilled long-term care facility. Guaranteed first year income, will pay travel expenses for interview. Interested physicians send curriculum vitae to William Wilson, Administrator, Springfield Community Hospital, PO Box 146, Springfield, Minn 56087 or call collect 507/723-4215 for more information. 5-10/82

Fifty physician multispecialty clinic in west central Wisconsin wants neonatologist, neurosurgeon, orthopedic surgeon, and otolaryngologist. Excellent cultural, educational, and recreational facilities. 90 miles from Minneapolis. Please contact James R Jepson, Administrator, Midelfort Clinic, Ltd, 733 West Clairemont Ave, Eau Claire, Wis 54702 or call 715/839-5266. 5-7/82

Otolaryngologist wanted, BE/BC to join multispecialty group in northern Wisconsin lakes region. Negotiable first year guaranteed salary; full partnership in second year. Full lab, x-ray and audiology services. Clinic located adjacent to modern hospital. Contact Dept 501 in care of the Journal. 5-7/82

Orthopedic Surgeon wanted for diagnosis, treatment, patient care and surgery in all areas of orthopedics. Requires MD degree and three years residency in Orthopedic Surgery. 50 hours per week, $70,000 per year. Contact Joyce Nimmo, Wisconsin Job Service, 211 N Parker Drive, Janesville, WI 53545. 6/82

PRIMARY CARE PHYSICIANS
BOARD CERTIFIED OR ELIGIBLE

We represent over 50 communities throughout the state which are seeking quality primary care physicians. These communities offer established service areas, generous practice and financial arrangements.

CONTACT:
Laurie Glowac or Fred Moskol
New Physicians for Wisconsin
University of Wisconsin Department of Family Medicine
777 South Mills Street, Madison, Wisconsin 53715
Phone: 608/263-4095

1-12/82

Obstetrics-Gynecology position available with an 18-member multispecialty group corporate practice. Modern clinic facility in Northeastern Wisconsin city of 100,000 enjoying a health and stable economy. Excellent recreational, educational, hospital, civic advantages. Please write: W J Mommaerts, Clinic Manager, West Side Clinic, SC, 1551 Dousman St, Green Bay, WI 54303. 6-9/82

Family Practitioners with option to join two-man group, or establish a group of their own. Ideal medical office facility; 60-bed accredited full service hospital which accomodates family practitioners. Located in the heart of paper making industry, Northeastern Wisconsin. Interested physicians write or call collect, Roger M Anderson, Kaukauna Community Hospital, 308 East 14th St, Kaukauna, WI 54130; tel 414/766-4211. 6-8/82

Family Physician. An existing physician's practice located in Green Lake, Wisconsin. This is an active practice that includes obstetrics, pediatrics, and adult medicine. Cross coverage with other physicians, and hospital has full-time emergency room physician coverage. Financial package includes a minimum guaranteed net income the first year. Contact: Donald R Brezicka, Executive Director, Berlin Memorial Hospital, 225 Memorial Dr, Berlin, Wis 54923; ph 414/361-1313. 5-7/82

Orthopedic Surgeon. Our hospital has more work than part-time orthopedic surgeon can handle! We are an active, energetic medical staff in the progressive, prestigious Green Lake area of Wisconsin. Remuneration is a minimum guarantee of $90,000. Contact Michael Tieman, MD, Chief of Surgery, Berlin Memorial Hospital, 225 Memorial Dr, Berlin, Wis 54923; ph 414/361-1313. 5-7/82

Dermatologist, Family Practitioner needed to join multispecialty group of 33 physicians dedicated to primary care in East Central Wisconsin community. City population 48,000, drawing area 100,000. Attractive income arrangements, association membership possible after one year, pension and profit sharing, extensive fringe benefits. Contact R B Windsor, MD, 1011 North 8th St, Sheboygan, Wis 53081; ph 414/457-4461. 5tfn/82

Family Practice Physician to share fully equipped medical office in central Wisconsin city. Opportunity for partnership and eventual purchase of practice. Excellent recreational, educational, hospital, and civic advantages. Send curriculum vitae to Dept 503 in care of the Journal. 6tfn/82

Surgeon with Thoracic general vascular training, Ophthalmologist, and ENT, to join a progressive multispecialty group of 17 physicians consisting of General/Family Medicine, General Surgery, Internal Medicine, OB-GYN, Ophthalmology, Orthopaedic Surgeon, Pediatrics/Adolescent Medicine, and Radiology. Subspecialties include: Pathology, Vascular Surgery, Cardiovascular Diseases, Gastroenterology and Endoscopy. We are located in a fast growing, scenic, lake country area between Milwaukee and Madison and can offer excellent hospital, schools, and recreational facilities. Full fringe benefit package. Contact: James F Dowd, Admin, Wilkinson Clinic SC, 915 East Summit Ave, Oconomowoc, Wis 53066; ph 414/567-4433. 9tfn/81

Physicians Exchange

continued

Doctors needed—in Wisconsin. All specialties and all locations. For confidential information, mail your CV to: Medicus, 1525 Wisconsin Ave, Grafton, WI 53024. 6tfn/82

Wausau Medical Center, SC, a 50-physician multispecialty group has openings for physicians in the following specialties: *Neurology, Otolaryngology, Cardiology* and *General Surgery* with a fellowship training in *Peripheral Vascular Surgery*. Competitive first-year salary, incentive plan thereafter. Comprehensive fringe benefits. New facility near new hospital. Located in beautiful, quiet, central Wisconsin, metropolitan area of 65,000. Recreational opportunities abundant. For more information contact: K L Day, MD, Wausau Medical Center, SC, 2727 Plaza Drive, Wausau, Wis 54401, or call collect 715/847-3351. 6tfn/82

General and vascular surgeon, FACS, Board certified, highly qualified, with several years of practice, would like to join an individual or group with an established practice in metropolitan Milwaukee area. Contact Dept 493 in care of the Journal. 3tfn/82

University of Wisconsin-Whitewater announcement of academic staff position for physician for Student Health Center.

Description: the Student Health Center at the University of Wisconsin-Whitewater, is seeking a second physician to serve a University age population.

Job Responsibilities: 1. Medical care and health counseling for students during established Health Center hours, Monday-Friday during the school year. 2. Participate in overall health program planning. 3. Medical supervision for primary care using a team approach. 4. Plan and implement health education/promotion programs. 5. Work cooperatively with other campus programs.

Qualifications: Degree from an accredited medical school Board eligible or certified preferred—family practice, pediatrics or internal medicine. Experiences with and empathy for college aged students. Experience in sports medicine, rehabilitation medicine, and/or family planning services would be beneficial. Licensed or eligible for license in State of Wisconsin.

University and community: The Health Center building is a modern facility designed for the health service and counseling center. A Planned Parenthood Association clinic is part of the Health Center program. UW-Whitewater is a public institution with an enrollment of 10,000 students. The city of Whitewater has a population of 12,300 and is located within the beautiful Kettle Moraine area 40 miles from Madison, 50 miles from Milwaukee and 100 miles from Chicago providing cultural and professional opportunities.

Application: Interested persons should apply in writing to: Ruth L Swisher, RN, Assistant Director, Chairperson, Search and Screen Committee, UW-Whitewater Student Health Center, Whitewater, WI 53190. Complete credentials consist of detailed vitae, three letters of recommendation, and official transcripts.

Application Deadline: June 30, 1982.

UW-Whitewater is an equal opportunity employer with an affirmative action plan. Women, members of minority groups, and persons with disabilities are encouraged to apply. 6/82

The Western Arizona Health Systems Agency has completed a physician manpower study to determine physician requirements by specialty. The results indicate that general practitioners are needed in Yuma County and ophthalmologists are needed in Mohave County. Both counties are in need of pediatricians, internists, and psychiatrists. For further information contact WAHSA, 281 W 24th St, Suite 144, Yuma, Arizona 85364; 602/726-8300. 6/82

Medical Placement Associates is recruiting in this area on behalf of clients throughout the country. Opportunities exist in *Anesthesiology, Gastroenterology, Gynecology, Internal Medicine, Obstetrics, Ophthalmology, Orthopaedics, Otolaryngology, Pediatrics, Radiology.* For further particulars call Steve Sell (collect) at (313) 557-3350, or write: West Ten Mile Road, Southfield, MI 48075. p6/82

Faculty Member Family Practice Program. The Black Hawk Area Medical Education Foundation is recruiting a Board Certified Family Physician to join its Family Practice Residency Program in Waterloo, Iowa. The program is community-based, affiliated with the University of Iowa College of Medicine, and part of the Iowa Network of Family Practice Residency Programs. The Waterloo metropolitan area has 125,000 people, four hospitals, and is well represented in the medical specialties. Applicants should have a MD degree, be eligible for licensure in Iowa, and should have several years of practice experience. Major duties include teaching residents in all aspects of patient care, including obstetrics, and also providing patient care. Other duties include some program administration and assisting in research from time to time. A salary in the range of $60,000 per year with an additional 20% fringe benefit package is offered. Other fringe benefits relating to retirement, moving expenses, and continuing education are provided. Please submit your resume to: Charles A Waterbury, MD, Program Director, Black Hawk Area Medical Education Foundation, 441 East San Marnan Dr, Waterloo, Iowa 50702; ph (319) 234-4419. Equal Opportunity Employer. 5-7/82

Family Practitioners and Internists. 40-bed hospital on the shores of Lake Superior in the Upper Peninsula of Michigan seeks additional staff in family practice and internal medicine. Year-round recreational area with opportunity for challenging medical practice. Office building, staff, and equipment negotiable. Contact William Hermann, Executive Vice President, Munising Memorial Hospital, Route 1, Box 501, Munising, Michigan 49862. p5-7/82

Family Practitioner. Immediate need to associate with busy, Board certified family practitioner in Tomah. Modern local clinic and hospital and formal association with 52-physician multispecialty clinic in La Crosse. Tomah is an active, growing community of 7,000 with a medical service area of 20,000. Contact: P S Shultz, MD, Medical Director, Skemp-Grandview-La Crosse Clinic, 815 S 10th St, La Crosse, WI 54601; ph 608/782-9760. 5-7/82

PUT EXPERIENCE TO WORK FOR YOU WHILE YOU SEARCH FOR A NEW CHALLENGE

Let years of experience as a healthcare professional and a Placement Counselor assist you in finding a new location with a new challenge. Physicians in all specialties are urgently needed throughout the country. Many types of situations available. Confidentiality assured.

Contact Donna Herschleb, RN
MEDICAL PROFESSIONAL PLACEMENTS
5222 Painted Post Drive, Madison, Wisconsin 53716
Phone: (608) 222-2927 *Licensed Employment Agency*

Busy OB/GYN Practice—associated required. Board certified or eligible. Guaranteed salary for first year with fringe benefits. Mohammad Shafi, MD, 606 W Wisconsin Ave, Milwaukee, Wis 53202; ph 414/276-7632. 4-6/82

Physician wanted to perform light physicals on a full or part-time basis. Ideal job for retiring physician. Contact Mike Stough collect at 513/621-8728. 10 tfn/81

The Racine Medical Clinic, a progressive cluster corporation of 25 physicians, is currently seeking an orthopedic surgeon and an invasive cardiologist. Full benefits, unlimited earnings and a full and exciting practice are offered. Please contact: Roger D Lacock, Administrator, Racine Medical Clinic, 5625 Washington Ave, Racine, WI 53406; ph 414/886-5000. 1tfn/82

Wanted. Board certified or eligible orthopedic surgeon to practice in conjunction with a 5-member surgery department in a 22-member multispecialty group. Present surgical specialties: thoracic and vascular surgery, general surgery and urology. The group is located in the upper midwest, in a city of 100,000 between two major metropolitan areas of greater than one million. If interested, please send CV to: Stephen Wagner, Kurten Medical Group, SC, 2405 Northwestern Ave, Racine, Wis 53404. All inquiries will be kept confidential. 12tfn/80

The Nicolet Clinic, SC, a young progressive 38-physician multispecialty group, has superb opportunities available for the practice of *General Surgery, Neurology,* and *Radiology.* Ideal family oriented community in metropolitan area with excellent schools, economy, culture and recreation for all four seasons. Located on northern Lake Winnebago. First year negotiable salary with option for full membership at nine months. Adjacent to modern regional hospital. Excellent benefits in addition to qualified profit-sharing plan and support for continued education. Contact in confidence: Curtis C Baltz, MD, Nicolet Clinic, SC, 411 Lincoln St, Neenah, Wis 54956; ph 414/727-4244. 3-6/82

Internist wanted. Board certified or eligible with/without subspecialty, to practice in conjunction with a 6-member Internal Medicine Department in a 22-member multispecialty group. Present subspecialties: Gastroenterology and cardiology. The group is in Southeastern Wisconsin, in a city of 100,000 between two major metropolitan areas of greater than one million. If interested, please send CV to: Stephen L Wagner, Kurten Medical Group, 2405 Northwestern Ave, Racine, Wis 53404. All inquiries will be kept confidential. 3tfn/82

Pediatric, Family Practice positions available in 13-member multispecialty group. Inquire: General Clinic of West Bend, Inc, 279 S 17th Ave, West Bend, Wis 53095. 2tfn/82

Locum tenens services. Wisconsin-licensed family physician available and also needed. Our Physicians do Office, Hospital, Emergency Room and OB work. Call or write: INTER-HEALTH, Attn: J Slazek, 5695 Merry Lane, Excelsior, MN 55331; ph 612/474-4372. 4-6/82

Physician wanted to share fully equipped medical office, x-ray, lab, fully staffed, small community, northern Wisconsin. Contact Dept 496 in care of the Journal. 5tfn/82

Family Physician or Internist to join three-man family and general practice group in the heart of North Central Wisconsin vacationland. First year guaranteed salary. Numerous fringe benefits. Clinic across from hospital. Send CV to: O M Francisco, MD, 221 E Washington Ave, Tomahawk, Wis 54487; ph 715/453-2147. 5tfn/82

Medical Facilities

Immediate solo practice available in Jefferson, Wisconsin, due to the recent death of Richard H Siedenburg, MD. Expandable building with three large lots available. Lease or purchase. Contact Miller Law Office, PO Box 417, Jefferson, Wisconsin 53549; ph 414/674-3345. g11tfn/81

Milwaukee. Busy family medical center for sale. Will introduce. Good for teaching interns and residents in Family Practice. Contact: R Gonzalez, MD; ph 414/344-1120 or 414/476-8624. 3-8/82

Wanted: X-Ray Equipment. Ultrasonic and Diathermy Units in workable condition. Reasonable. Info: Call 414/444-7525. 5-7/82

Office spaces for rent. New professional building in Menomonie, Wis, city of 14,000, 70 minutes from Minneapolis/St Paul on Interstate 94. Building has dental offices. Excellent opportunity for private practice. Contact Ryder Realty, 815 6th Ave, Menomonie, Wis 54751; ph 715/235-8800. 5-7/82

For Sale: Portable Burdick EKG with cart. Bio-refrigerator; sterilizer; portable electric typewriter; centrifuges (2); stainless disposal cans; 3-M dry photocopier; infant scale; small instruments; incidental lab equipment. Contact 1/414-769-9697 evenings. All excellent condition. Should be seen. 6/82*

Miscellaneous

Physicians Signature Loans to $50,000. Up to 7 years to repay. No prepayment penalties. Prompt, courteous service. Physicians Service Assn, Atlanta, GA. Toll-Free (800) 241/6905. 4tfn/82*

Shopping for an Airplane? Lowest prices in US on new and used aircraft. All types available, prompt delivery. We are wholesalers—Call us Toll-Free (800) 241/6905. Physicians Service Assn, Atlanta, GA. 4tfn/82*

Physician Assistant with 2 years of family practice, emergency room, and hospital experience seeks position with rural family practice clinic or small hospital setting. Enthusiastic, hardworker. Contact Sarah Glover, PA-C, 6931 County PD, Madison, Wis 53711. p6/82

Position wanted: Adult nurse practitioner. Master's prepared ANA certified practitioner wishes to work with family physician or general internist. Skilled in assessment and evaluation, management of acute and chronic health problems with protocols, health maintenance and teaching, and counseling. Interested in older adult population. Wishes to relocate in other than metropolitan setting.Contact Dept 504 in care of the Journal. p6/82

Real Estate

A SAFE TAX SHELTER. Land ownership offers more. The new A.C.R.S. (Accelerated Cost Recovery System). Depreciation + Inflationary Appreciation + Investment Credits, all put money into your pocket. FAITH REALTY—Est 1960, Farm Specialist-Tax Consultant, Whitewater, Wis 53190 (414/473-2779). PS: Who do you know who wants to buy a farm? p3-8/82

Meetings/CME Courses

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates: 40¢ per word, with a minimum charge of $16.00 per listing. BOXED LISTINGS: $32.00 per column inch. COPY DEADLINE for Continuing Medical Education listings is tenth of the month preceding the month of publication; e.g., copy for the August issue is due by July 10. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 800/362-9080. For listing of other meetings see the Special issue of the Journal of the American Medical Association: Continuing Education Courses for Physicians for period Sept 1, 1981 through Aug 31, 1982.

WISCONSIN

JUNE 16-AUGUST 4, 1982: *University Forum on Health,* eight weekly lectures on Wednesday evenings from 7-9 pm in Room 3650, Humanities Building, University of Wisconsin-Madison. See details elsewhere in this section.

JULY 12-16, 1982: *Cardiac Rehabilitation Workshop,* La Crosse. Info: Philip K Wilson, Workshop Unit, LaCrosse Exercise Program, Mitchell Hall/University of Wisconsin-LaCrosse, LaCrosse, Wis 54601; ph 608/785-8686.

JULY 16-17, 1982: Wisconsin Society of Obstetrics and Gynecology, Leathem Smith Lodge, Sturgeon Bay.

JULY 23-24, 1982: *2nd Annual Common Emergency Care Problems: Managing the Unmanageable,* Wisconsin Center, Madison. Sponsored by University of Wisconsin-Extension, Department of Continuing Medical Education; University of Wisconsin Emergency Medical Services Program; and U S Department of the Army, Office of the Surgeon General. Approved 10 credit hours of AMA Category I; University of Wisconsin-Extension CEH's, 10 hours; AOA Category 2-D plus Emergency Medical Physicians applied for. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

JULY 30-AUG 1, 1982: *EKG Interpretation and Arrhythmia Management,* Abbey Resort, Lake Geneva. Fee: $245 physicians; $130/Nurses & Technicians. Approved 13 credit hours Category I of AMA-PRA and prescribed AAFP; ACEP. Info: International Medical Education Corporation, 64 Inverness Drive East, Englewood, CO 80112; ph 800/525-8651 or 303/740-8445, ext 123. 4-6/82

JULY 18-24, 1982: Seventh Annual *Wellness Promotion Strategies Workshop,* University of Wisconsin-Stevens Point. Sponsor: UWSP Institute for Lifestyle Improvement. Cooperating organizations: American Medical Association, Marshfield Clinic, Medical Self-Care Magazine, President's Council on Physical Fitness & Sports, St Michael's Hospital, Stevens Point. Director, Health Center, UWSP: Bill Hettler, MD. Graduate and undergraduate credit from UWSP, Continuing Education Units and Continuing Medical Education (Category I) credits are being offered. Further info: Wellness Promo VII, Delzell Hall, UW-Stevens Point, Stevens Point, WI 54481.

AUGUST 6-8, 1982: Wisconsin Dermatological Society summer meeting, Lake Geneva, Wis. Info: Robert A McDonald, MD, 1313 Fish Hatchery Rd, Madison, Wis 53715.

AUGUST 14, 1982: *Fifth Annual Sports Medicine Program,* Waunakee. Sponsored by University of Wisconsin, Division of Orthopedic Surgery, Section of Sports Medicine, and University of Wisconsin-Extension Department of Continuing Medical Education. Approved 10 credit hours AMA Category I, AOA Category 2-D, AAFP, University of Wisconsin-Extension Continuing Education Hours. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

AUGUST 20-21, 1982: *Second Annual Green Lake Conference on Infectious Diseases.* Heidel House Resort, Green Lake, Wis. Sponsored by Berlin Memorial Hospital. Approved 12 credit hours of Category I. For more information contact: Linda E Nevers, Berlin Memorial Hospital, 225 Memorial Dr, Berlin, Wis 54923; ph 414/361-1313. 5-7/82

SEPTEMBER 9-10, 1982: Wisconsin Surgical Society, Holiday Inn and/or Radisson Hotel, La Crosse.

SEPTEMBER 9-12, 1982: Wisconsin Society of Anesthesiologists, Concourse Hotel, Madison.

SEPTEMBER 9, 1982: *Delivery of Health Care Services to Indochinese Refugees,* Wisconsin Center, Madison. Sponsored by University of Wisconsin-Extension, Dept of Continuing Medical Education, Wisconsin Dept of Health and Social Services, Division of Health, Bureau of Community Health and Prevention, Refugee Program; and University of Wisconsin School of Medicine. Elective 6 hours of AMA, AOA, AAFP. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, WI 53706; ph 608/263-2856.

SEPTEMBER 9-11, 1982: Wisconsin Society of Internal Medicine and American College of Physicians joint meeting, Holiday Inn Downtown, Green Bay. Info: Kim Marggraf, Wisconsin Society of Internal Medicine, 611 East Wells St, Milwaukee, Wis 53202.

SEPTEMBER 16, 1982: *Infection Control for Community Hospitals,* University of Wisconsin Clinical Science Center, Madison. Sponsored by University of Wisconsin-Extension, Continuing Medical Education; and University of Wisconsin School of Medicine, Dept of Medicine, Infection Control Unit. Approved AMA Category I, AAFP, AOA, University Contiing Education Hours. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, WI 53706; ph 608/263-2856.

SEPTEMBER 18, 1982: Wisconsin-Upper Michigan Society of Ophthalmology Annual Meeting, Marshfield. Info: Michael R McCormick, MD, Secretary-Treasurer, 102 East Main St, Waukesha, Wis 53186 (phone: 414/547-3352).

SEPTEMBER 20-24, 1982: *Cardiac Rehabilitation Workshop,* La Crosse. Info: Philip K Wilson, Workshop Unit, LaCrosse Exercise Program, Mitchell Hall/University of Wisconsin-LaCrosse, LaCrosse, Wis 54601; ph 608/785-8686.

SEPTEMBER 22-25, 1982: *7th Annual Nuclear Cardiology Symposium,* Red Carpet Hotel, Milwaukee. Sponsored by Mount Sinai Medical Center, Milwaukee; University of Wiscon-

sin-Extension Continuing Medical Education, University of Wisconsin School of Medicine, Milwaukee Clinical Campus, Cardiovascular Disease Program; American Health Association; and Society of Nuclear Medicine. AMA Category I, VOICE, University of Wisconsin-Extension Continuing Education Hours. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, WI 53706; ph 608/263-2856.

OCTOBER 9, 1982: Second Annual Meeting of the *Wisconsin Association of Senior Physicians,* at State Medical Society Headquarters in Madison. Info: Norman Clausen, MD, President, WASP, PO Box 1109, Madison, Wis 53701.

OCTOBER 9-10, 1982: Wisconsin Allergy Society, Pioneer Inn, Oshkosh.

OCTOBER 16, 1982: Wisconsin Radiological Society, Concourse Hotel, Madison.

OCTOBER 20, 1982: Milwaukee Ophthalmological Society Fall Meeting at University Club in Milwaukee. Info: Michael R McCormick, MD, Secretary, 102 East Main St, Waukesha, Wis 53186 (phone: 414/547-3352).

NOVEMBER 5, 1982: Wisconsin Orthopaedic Society, Olympia Resort, Oconomowoc.

OTHERS

JUNE 30-JULY 4, 1982 (Virginia): Seventh Annual *Convention of the American College of International Physicians, Inc* (ACIP), at Williamsburg Hilton Hotel, Williamsburg, Va. Includes seminar on "The Marketing of Physician Services" as part of a physician's medical practice; Category 1 CME credits will be given attendees. Info: ACIP, 3030 Lake Avenue, Fort Wayne, Ind 46805 (phone: 219/424-7414).

JULY 19-21, 1982 (Massachusetts): *Trauma Center Conference,* sponsored by American Society of Law & Medicine, at Hyatt Regency Hotel, Cambridge, Mass. Conference will focus on the many legal, financial, medical, and political problems surrounding trauma center designation and operation, and is especially designed for hospital personnel. Meets criteria for 16 credit hours in Category 1/PRA-AMA. Info: Conference Registrar, American Society of Law & Medicine, 765 Commonwealth Ave, 16th floor, Boston, MA 02215 (phone: 617/262-4990.

JULY 29-AUGUST 1, 1982 (Illinois): *International Doctors in Alcoholics Anonymous, Annual Meeting.* Hotel reservations directly at Ramada the O'Hare Inn, 6600 N Mannheim Rd, Des Plaines, Ill 60018 or call 312/827-5131 or 800/288-2828. (Be sure to specify IDAA for special rates). Further information contact Secretary IDAA, 1950 Volney Rd, Youngstown, Ohio 44511; ph 216/782-6216. g2tfn/82

AUGUST 29-30, 1982 (Colorado): *Achieving a Successful Medical Retirement seminar,* conducted by the American Association of Senior Physicians (AASP), in Denver. Seminar costs: $150 for ASSP members; $175 for nonmembers. Contact: AASP, 536 North State St, Chicago, IL 60610; phone 312/644-3092.

SEPTEMBER 22-25, 1982 (Oregon): *Fifth National Conference on the Impaired Physician,* Portland, Ore, jointly sponsored by the Oregon Medical Association and the AMA.

STATE MEDICAL SOCIETY OF WISCONSIN Dates and Locations of Annual Meetings 1982-1992

All meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) and the new Hyatt Regency as the headquarters hotel with the exception of 1985, when the meeting will be held at the LaCrosse Convention Center.

1982—May 13-15	**1987—Mar 26-28**
1983—Mar 24-26	**1988—Apr 28-30**
1984—Mar 29-31	**1989—Apr 13-15**
1985—Apr 25-27	**1990—Apr 26-28**
1986—Apr 17-19	**1991—Apr 18-20**
	1992—Apr 23-25

Meeting days will be Thursday and Friday; the first session of the House of Delegates will convene on Thursday, the second and third on Friday. Scientific programming will be on Friday and Saturday.

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701. Local telephone: 257-6781; toll-free in Wisconsin: 1-800/362-9080.

1982 UNIVERSITY FORUM ON HEALTH

Presented by the University of Wisconsin-Madison Medical School and the Schools of Allied Health Professions, Nursing, and Pharmacy, all components of the Center for Health Sciences.

Weekly lecture/discussions on Wednesday evenings from 7-9 pm in Room 3650, Humanities Building.

Wednesday evenings—June 16 to August 4

Eight outstanding speakers will focus on health from the perspective of personal, professional, and social responsibilities:

- June 16—Philip Lee, MD, University of California, *The Nation's Health: Individual and Social Responsibility*
- June 23—William Nolen, MD, Litchfield, Minnesota, *Surgery and Healing*
- June 30—Don E Detmer, MD, UW-Madison Professor of Preventive Medicine and Surgery, *Physician-patient Relationships*
- July 7—Charlotte Anderson-Smith, RPh, MS, UW-Extension, *Treat Yourself Right: Rational Self-medication*
- July 14—Nancy Watts, PhD, Education Provost, Massachusetts General Hospital, *Taking Control of Your Own Health?*
- July 21—Alfred E Harper, PhD, UW-Madison Professor of Biochemistry and Nutritional Sciences, *Diet, Nutrition and Health*
- July 28—Jerry J Noren, MD, UW-Madison Assistant Professor of Preventive Medicine, *Health and Environment*
- August 4—Catherine Murphy, RN, EdD, Boston, College, *Ethical Decisions in Health.*

Moderator: Joseph M Benforado, MD, Professor of Medicine, Center for Health Sciences.

All interested persons may attend free of charge, or may register for the Forum as a one-credit Summer Sessions course.

Further information: Howard L Stone, PhD, Director, Office of Educational Resources, School of Medicine, Medical Sciences Center, 1300 University Ave, Madison, Wis 53706 (phone: 608/263-4714).

OCTOBER 10-16, 1982 (Florida): AMA's 1982 CME/Golf Digest-Tennis Program at the Doral Country Club and Hotel, Miami. Reservation deadline: September 1. Contact Elaine M Tejcek at 312/751-6057 for details.

OCTOBER 11-14, 1982 (Hawaii): *World Medical Association* (WMA) Continuing Medical Education Meeting, Honolulu, Hawaii. Program offers total of 19 hours of Category 1 CME credits. Info: WMA, North American Region, 536 N State St, Chicago, Ill 60610, or call Ms Eva Stone 312/751-6230.

OCTOBER 26-30, 1982 (California): 42nd Annual Conference of the American Medical Writers Association (AMWA) in Los Angeles. Info: AMWA National Office, 5272 River Rd, Suite 370, Bethesda, Md 20816 (phone: 301/986-9119).

OCTOBER 31-NOVEMBER 6, 1982 (India): *First US-India Radiology Conference,* sponsored by the Medical College of Wisconsin (MCW), Milwaukee, Wisconsin, and the Indian Radiological Association, New Delhi. It is recognized by the Atomic Energy Commission of India, Bombay. Program director: Jagmeet S Soin, MD, associate professor of radiology and medicine at MCW. This CME course meets the criteria for 30 credit hours in Category I of the Physician's Recognition Award of the AMA and 30 credit hours of Liaison Committee on Continuing Medical Education Category 1 CME credits. Info: Jagmeet S Soin, MD, MCW, 8700 West Wisconsin Ave, Milwaukee, Wis 53226, or call toll-free 1-800-558-4355. In Wisconsin call 414/784-8430.

AMA

JUNE 13-17, 1982: Annual AMA House of Delegates, Downtown Chicago Marriott, Chicago, Ill.

JUNE 19-23, 1983: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 4-7, 1983: Interim AMA House of Delegates, Los Angeles, CA.

DECEMBER 5-8, 1982: Interim AMA House of Delegates, Miami Beach, Fl. ■

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AMA 1982 CME/Sports Getaway

The American Medical Association's 1982 CME/Golf Digest-Tennis Program will be held October 10-16 at the Doral Country Club and Hotel, Miami, Florida.

Five days of sports instruction and tournament play, AMA Video Clinics on alcoholism and hypertension, and a four-hour seminar on retirement planning are highlights of the week-long getaway. The Video Clinic courses offer a total of 8 Category 1 credit hours.

Golf pro Bob Toski, his Golf Digest staff, and tennis greats Arthur Ashe and Pacho Castillo will lead instruction programs for physicians and their sports-minded spouses. Capping a full schedule of individual lessons, golf and tennis clinics, and championship tournaments will be a final-night awards dinner.

The AMA Video Clinic on alcoholism discusses the diagnosis, pathophysiology and treatment of alcoholism, with particular emphasis on long-term management. Medical consultant is Alan Brovar, MD, Career Teacher for the National Institute on Alcohol Abuse and Alcoholism, and Assistant Professor of Psychiatry at the University of California School of Medicine, Los Angeles.

Donald G Vidt, MD, Head of the Clinical Section of the Department of Hypertension and Nephrology at the Cleveland Clinic Foundation, Cleveland, Ohio, is the course director for the AMA Video Clinic on hypertension. This program focuses on hypertension risk factors, clinical evaluation of the hypertensive patient, and the use of available antihypertensive agents.

Both Video Clinics will be supplemented by faculty who will lead discussion and field questions.

Karen Zupko, Director of the AMA Department of Practice Management, will be joined by insurance consultant Deane H Tank, CLU, in a four-hour course designed to help physicians and spouses prepare for eventual retirement or possible career change. The discussion will cover personal and psychological planning, handling practice closings, intermediate practice transitions, and insurance and financial considerations.

Costs of the golf program are $1199 for physicians, $799 for golfing spouses, and $575 for non-golfing spouses. Costs of the tennis program are $995 for physicians, $650 for playing spouses, and $575 for non-playing spouses. Non-players will enjoy swimming, shuffleboard, sightseeing, and many other activities offered at the spectacular 2,400-acre Doral resort.

Deadline for reservations is September 1. Contact Elaine M Tejcek at AMA: 312/751-6057 for details. ■

Cancer Lectureship Series available from UW Medical Library

The Audiovisual Unit of the University of Wisconsin Middleton Health Sciences Library has been given videotapes of the presentations by cancer specialists in the Cancer Lectureship Series sponsored by St Luke's Hospital in Milwaukee and supported through a grant from Security Savings and Loan since 1980. St Luke's wished to make the tapes of these lectures available as a service to Wisconsin physicians through loan by the Library. There also are audiocassette copies for those who do not have access to ¾ inch, U-Matic videoplayback equipment.

Listed below are the videocassette and audiocassette call numbers, respectively, beside each program. The last two are only available on audiocassette. They may be requested for seven-day loan from Middleton Health Sciences Library, Audiovisual Unit, 1305 Linden Drive, Madison, WI 53706. To call toll-free, dial (from Milwaukee area) 342-3020, ext 26957, or (from rest of state) 800-362-3020, ext 26957. If possible, the requests should be made via hospital or public libraries.

* * *

VC 743 **Detection and evaluation of early**
AC 478 **breast cancer**
Benjamin Byrd. January 24, 1980. 47 min.

VC 744 **Primary radiation therapy without**
AC 479 **mastectomy for early breast cancer**
Jay Harris. March 13, 1980. 37 min.

VC 745 **New approaches to the treatment**
AC 480 **of malignant melanoma.**
Steven A Rosenberg. April 17, 1980. 60 min.

VC 746 **Endocrine management in metastatic**
AC 481 **cancer of the breast.**
Samuel A Wells Jr. May 15, 1980. 41 min.

VC 747 **Management of advanced breast cancer.**
AC 482 Marc E Lippman. August 21, 1980. 54 min.

VC 748 **Therapy of acute myelocytic leukemia.**
AC 483 Janet B Cuttner. September 4, 1980. 39 min.

AC 484 **Science or anti-science: which will win the cancer struggle?**
Bernard Fisher. September 25, 1980. audiocassette, 59 min.

VC 749 **Influence of pathologic factors in**
AC 485 **breast cancer management.**
Robert VP Hutter. October 2, 1980. 81 min.

VC 750 **Psychological adaptation to breast cancer.**
AC 486 Jimmie CB Holland. November 6, 1980. 54 min.

VC 751 **Adjuvant therapy for breast cancer:**
AC 487 **American experience.**
James F Holland. December 11, 1980. 49 min.

VC 752 **Staging of carcinoma of the lung with**
AC 488 **emphasis on gallium scanning.**
Tom R DeMeester. March 26, 1981. 62 min.

AC 489 **Laetrile, the cult of cyanide.**
Victor Herbert. May 7, 1981. audiocassette, 61 min.

VC 753 **New approaches to treatment of**
AC 490 **rectal cancer.**
Steven A Rosenberg. June 18, 1981. 54 min.

VC 754 **Conservation surgery for laryngeal cancer.**
AC 491 Hugh F Biller. July 16, 1981. 40 min.

VC 755 **Adjuvant therapy in advanced**
AC 492 **lymphomas, Hodgkin's disease, and breast cancer.**
Gianni Bonadonna. September 19, 1981. 62 min.

VC 783 **Management of ovarian cancer.**
AC 508 C Thomas Griffiths. October 24, 1981. approx 60 min.

VC 784 **Management of ovarian cancer.**
AC 509 F Anthony Greco. October 24, 1981. approx 60 min.

VC 785 **Current uses of intraoperative**
AC 510 **radiation therapy.**
Mitsuyuki Abe. November 10, 1981. approx 60 min.

VC 786 **Current trends in head and neck cancer.**
AC 511 Charles J Krause. November 19, 1981. approx 60 min.

VC 787 **Lung cancer: novel treatments and**
AC 512 **successful adaptation to the illness.**
James F Holland and Jimmie CB Holland. December 10, 1981. approx 60 min.

VC 788 **Surgical therapy of carcinoma of**
AC 513 **the bladder.**
Jerome P Richie. January 21, 1982. approx 60 min.

VC 789 **Recent developments in the**
AC 514 **management of breast cancer.**
Marc E Lippman. February 18, 1982. approx 60 min. ■

News You Can Use

By EARL THAYER, Secretary / BERNIE MARONEY, Assistant Secretary

SMS SUES OVER MEDICAID MENTAL HEALTH SERVICES. On May 19 the State Medical Society filed a complaint in the Federal District Court of Western Wisconsin seeking to enjoin further implementation of a system which places Community Mental Health Boards in the role of "gatekeeper" to Medicaid patients in need of psychiatric services. The Society is concerned that economic criteria are now being used by the boards to determine what care will be delivered without regard to the medical needs of severely mentally ill persons. The gatekeeper system has been operating in Wisconsin since last January, even though the SMS has repeatedly alleged it violates federal law and in any case requires approval from the US Department of Health and Human Services before it can be implemented. The Federal Government has extended its review of the situation for an additional 90 days before determining whether the State's change in procedure complies with Federal Medicaid requirements.

Prior to initiating the lawsuit, the Medical Society lobbied at both the state and federal levels to adopt a strategy which would have allowed for the continued coverage of medically indicated treatment while still achieving a savings to the Medicaid program. "By shifting the burden of determining what services should be authorized to counties, the State has sidestepped the question of whether it really wants to continue funding social services to the worried well," said Pauline Jackson, MD, who chairs the SMS's Committee on Mental Health. The Society has wanted the Department to undertake a review of diagnostic coding procedures in order to separate out and eliminate coverage of treatment for those services which are thought to be of little value.

Previously psychiatrists, like all other physicians, contracted directly with the State to provide medical services under the terms of long-standing provider agreements. "In essence, Wisconsin has illegally discriminated against psychiatrists and their mentally ill patients," Doctor Jackson said. "All other Medicaid recipients who need medical care can go directly to their physician under the system; but the mentally ill may have to go to some provider who may not have any medical training for evaluation and subsequent treatment."

"It's ironic," she continued, "that the most highly skilled specialists in the treatment of mental illness are being locked out of the system. If you happen to have been trained as any other physician specialist, you need not go through the Community Board authorization system to treat for mental illness. In fact, we know from the Department's own studies that a significant amount of mental health care is provided by family physicians and general practitioners. This is an essential component of a complicated referral system which the Bureau of Health Care Financing has never really attempted to understand."

The Society is concerned that the existing confusion has already resulted in further deterioration in the status of chronically mentally ill persons. "We cannot continue to allow such devastating blows and disruption in the continuity of care to our most vulnerable population," Doctor Jackson said. The Medical Society anticipates that several affected organizations will want to file briefs in the case. Representing the State Medical Society and its 5,000-plus member physicians is the law firm of Broeker, Hartfeldt, Hedges and Grant of Madison.

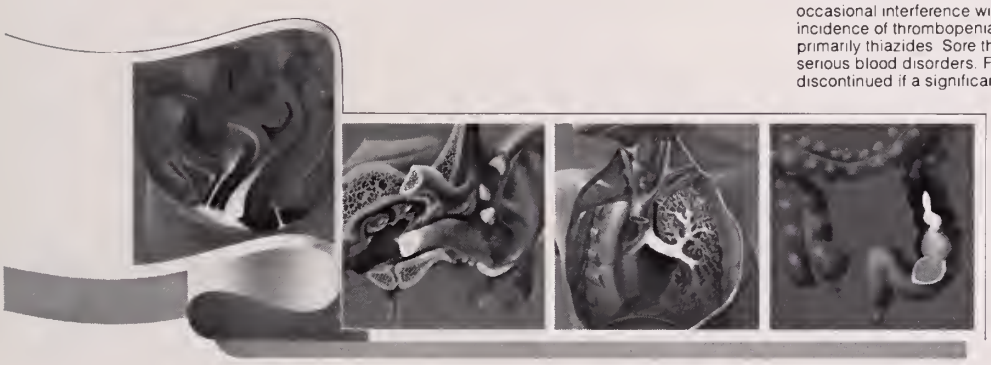
MEB MEMBER JACKSON CHOSEN TO IMPAIRED PHYSICIAN EFFORT. Medical Examining Board member Gwen Jackson, Milwaukee, in April was elected co-chair of the Coordinating Council on Physician Impairment. Ms Jackson, who serves as the public member of the MEB, succeeds Rudolf Link, MD, Madison, in the post. SMS President Gerald C Kempthorne, MD, Spring Green, continues to serve as co-chair representing the State Medical Society on the six-member council established in 1980 by the SMS and the MEB. Also named to the Coordinating Council to represent the MEB was Susan Behrens, MD, Beloit.

In a related matter, the managing committee for the newly formed Statewide Impaired Physicians Program held its first meeting April 28 in Madison. The committee consists of: Gerald C Kempthorne, MD, Spring Green, (chair); Roland Herrington, MD, Milwaukee (project director); Bela Maroti, administrator, De Paul Rehabilitation Hospital, Milwaukee; Fred Koenecke, MD, Madison; and Gerald Schley, president, Milwaukee Psychiatric Hospital. In addition to appointing a committee representative, the Milwaukee Psychiatric Hospital announced that it will contribute $5,000 to the statewide program. The managing committee also established a timetable for implementing the statewide impaired physician program which was approved by the SMS Board of Directors in March. ■

Bactrim™
(trimethoprim and sulfamethoxazole)
succeeds

Bactrim is useful for the following infections when due to susceptible strains of indicated organisms (see indications section in summary of product information):

Expanding its usefulness in antimicrobial therapy



in recurrent UTI...
a continuing record of high clinical effectiveness against common uropathogens

in acute otitis media in children...
effective against both major otic pathogens...with *b.i.d.* convenience

in acute exacerbations of chronic bronchitis in adults...
clears the sputum and lowers its volume...on *b.i.d.* dosage

in shigellosis...
faster relief of diarrhea than with ampicillin[2]

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. Limited clinical information presently available on effectiveness of treatment of otitis media with Bactrim when infection is due to ampicillin-resistant *Haemophilus influenzae*. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.

For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.

For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.

Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: *General:* Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:

Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.

Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.

For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.

ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:

Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days.

PNEUMOCYSTIS CARINII PNEUMONITIS:

Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets*, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100; Prescription Paks of 20 and 28. *Tablets*, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40. *Pediatric Suspension*, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); cherry-flavored—bottles of 100 ml and 16 oz (1 pint). *Suspension*, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).

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Bactrim™ succeeds

in recurrent urinary tract infections*

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1. Rubin RH, Swartz MN: *N Engl J Med* 303 426-432, Aug 21, 1980. 2. Data on file, Medical Department, Hoffmann-La Roche Inc.

Bactrim™ DS
160 mg trimethoprim and 800 mg sulfamethoxazole
DOUBLE STRENGTH TABLETS

maximizes results with B.I.D. convenience

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*due to susceptible strains of indicated organisms

Please see previous page for summary of product information.

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WISCONSIN MEDICAL JOURNAL

JULY 1982

- "Blue Book" issue. A reference source on medicolegal, socio-economic, legislative, governmental matters of direct concern to the physician. Also a reference source on State Medical Society organizational structure, other related organizations, and state government agencies.
- Legislative wrap-up
- Summary report, House of Delegates

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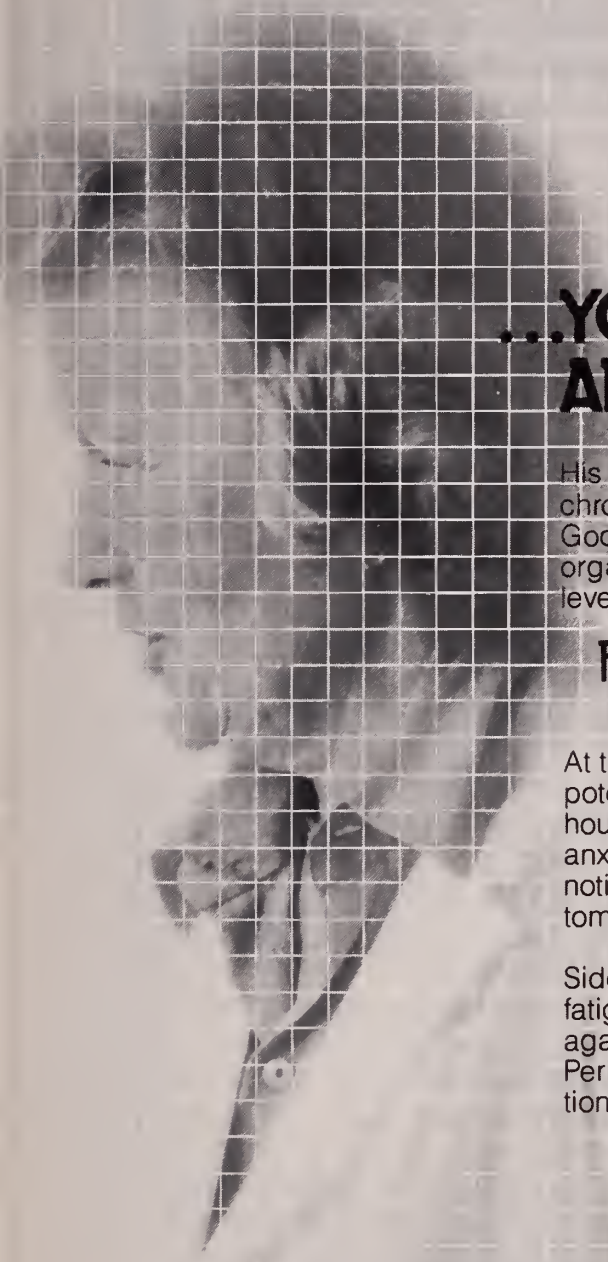
THE PATIENT THINKS HE HAS HEART TROUBLE...



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His presenting symptoms: palpitations, chest pain, chronic exhaustion and occasional difficulties in breathing. Good reason for concern. A complete workup uncovers no organic dysfunction, but it *does* reveal excessively high levels of anxiety and apprehension.

For rapid relief you prescribe Valium (diazepam/Roche)

At times like this, Valium (diazepam/Roche) can be a potent therapeutic ally. It works promptly. Within just a few hours, the patient begins to feel calmer. And in a few days, anxiety relief not only becomes more pronounced but a noticeable reduction in anxiety-generated somatic symptoms also occurs.

Equally important, Valium is generally well tolerated. Side reactions more serious than drowsiness, ataxia and fatigue are rare. Patients should, of course, be cautioned against driving or drinking alcohol while on Valium therapy. Periodic reassessment of the need for antianxiety medication should also be performed.

VALIUM® (IV)

diazepam/Roche

2-mg, 5-mg, 10-mg scored tablets

BECAUSE YOU'RE CONVINCED THE PATIENT NEEDS IT

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VALIUM®(diazepam/Roche)

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.
Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation. The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.
Dosage: Individualize for maximum beneficial effect. *Adults:* Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed, adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).
How Supplied: For oral administration, Valium scored tablets—2 mg, white; 5 mg, yellow; 10 mg, blue—bottles of 100* and 500;* Prescription Paks of 50, available in trays of 10.* Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25,† and in boxes containing 10 strips of 10.†

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Editorials

WAYNE J BOULANGER, MD, *Editorial Director*

Official positions of the Society will be expressly identified as such; all others are views of the writer and not necessarily those of the Society.

Medical marketing

THE COMMISSION ON PUBLIC INFORMATION recommended and requested that the article on medical marketing on page 150 be published in the *Wisconsin Medical Journal*. That Commission arranged for the interview in an effort to learn more about medical marketing, a subject receiving increasing attention throughout the medical community.

The Editorial Board did not share the enthusiasm of the Commission on Public Information in regard to the subject of medical marketing, although there were mixed reactions. Here are some of the Editorial Board comments:

"I don't like the concept, and I don't like this interview. Garbage!"

"If this is classified as advertising, then I have no objection to its publication as long as we get the going rate. As a special article or editorial, I have strong objections to the publication of this material."

"The interview is informative and factual. It is important that physicians understand the legitimacy of educating themselves in what patients want and need, and at the same time, educating patients about physicians' services."

"Marketing is becoming a popular term. In the medical profession there are more effective, more efficient and simpler procedures to promote good health care. One is the well known 'supply and demand.' Time and economic factors will remedy the distribution factor. Addition of more sophisticated patterns merely places more third parties and obstacles between the professional individual and the citizen patient. I am reluctant to approve publication."

In deference to the Commission on Public Information the interview on medical marketing is being published this month. I guess I've been around too long to accept the idea that medicine must be marketed. If physicians practice good, honest medicine, it shouldn't be necessary to make a business out of the profession. Certainly preventive medicine and patient education can be continued without promoting it as medical marketing.

I wonder if the medical marketers had ever considered having evening office hours for their clients. As a boy growing up in a small town, I can recall my father having evening office hours six nights a week and returning to the office on Sunday mornings as well. My three sons were overexposed to medicine by both their grandfathers as well as seeing very little of me during their formative years. They all decided at early ages that medicine was not for them.

In any event Medical Marketing is presented, and the Editorial Board hopes that it will stimulate responses from Wisconsin physicians. —VSF

Water pollution

A CIRCUIT JUDGE in Illinois ruled after a 40-day trial that "a conclusion that fluoride is a safe and effective means of promoting dental health cannot be supported by the record of testimony."

Apparently he was not impressed by the expert testimony from such organizations as the American Medical Association, American Dental Association, American Cancer Society, and the Center for Disease Control in Atlanta.

However, he must have been swayed by a militant female who opposed mass medication. She regarded fluoridation as a step toward adding other drugs to water supplies such as birth control medication, antibiotics, and tranquilizers.

With reasoning as specious as hers and with only a slightly wilder imagination, one could come up with some pretty exotic additives to our basic hydration. How about a shake of saltpeter to soothe the sexually stimulated? (As college students we were all convinced that the barrels of gravy were liberally laced with the villainous saltpeter.) Then there is the possibility of a generous jigger of citrate of magnesia for the chronically constipated, a problem that seems to persistently plague the elderly. A suspension of megavitamins might mollify the food fadists. A modicum of spiritus frumenti would alleviate the longings of the alcohol abuser. Someday a successor to Ponce de Leon might really find the Fountain of Youth, and this would make a fine addition to our water supply. This would really be essential after a few years if the contraceptive concoction proposed by our lady as noted above had diminished our youth population.

As a last resort, and after a long and unproductive life, the water works might dash in a dollop of embalming fluid.—VSF■

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Wisconsin Medical Journal 1982

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Legal responsibilities of the physician-patient-hospital relationship

SEVERAL QUESTIONS pertaining to the physician-patient-hospital relationship were addressed by the Society's legal counsel. The questions and excerpts from the opinion of legal counsel are presented below.

1. Is there a special legal responsibility of a physician to his hospitalized patient?

There are no Wisconsin statutes which directly cover or govern the question set out above. The basic statutes on hospitals relate to construction, safety, standards of maternity departments, and licensure.

In general terms, the courts have held that a physician has a legal responsibility to his patients, hospitalized or not, to furnish that degree of professional skill which meets the standard of professional care and to give such professional attention to the patient as the case requires. By statute the physician must inform patients of alternate viable modes of treatment. A physician is not legally excused for inattention to one patient on the grounds that he was occupied with the needs of others.

A physician has a continuing responsibility to his hospitalized patient at least to the point where the latter is well enough to be discharged, or sooner leaves without the physician's authorization. A physician may be charged with abandonment for neglecting a patient who needs his care, whether during or after hospitalization. Once a physician has agreed to care for a particular patient, he must continue to do so until the patient discharges him or no longer needs his professional services. He may be legally liable for neglect of the patient, or for ceasing to care for him until another physician has replaced him, unless he has been clearly discharged by the patient before the relieving physician actually takes over.

While a hospital nurse or technician may technically be in the employ of the hospital, a physician may incur legal liability for permitting a nurse or technician to carry out his treatment orders or assist him when he knows or has reasonable cause to know that such person is unsuitable for such duties by reason of inadequate training, experience, judgment or personality defect.

The essence of negligence is the absence of the degree of care owed by one person to another. Legal liability results when negligence causes physical injury or monetary damage to the object of such negligence. The principles of law involved are few, but their application depends upon the facts of the case, frequently as evaluated by expert testimony, and as found by a jury or court.

There also has been a recent trend toward the definition and codification of social or human rights of patients apart from their right to receive care meeting the appropriate standards of professional skill. A patients' bill of rights for nursing home and residential care facility residents has been enacted both by statute and administrative rule. Several hospitals have adopted or considered such a statement of rights. While not affecting the nature of care given, this expression of patients' rights does affect the environment within which this care is provided.

2. What is the joint legal responsibility of the physician and hospital to a hospitalized patient?

The courts in the past tended to distinguish the *administrative* negligence of a hospital from the *professional or medical* negligence of a physician. The first is concerned largely with the furnishing of safe and adequate facilities, equipment, food and related services and the carrying out of such routines as bathing or other general care. The other is concerned with professional treatment or care by the physician, or the carrying out of the orders of a physician by a nursing staff, technicians or others. A hospital was liable in general for *administrative* negligence, and a physician for *professional* negligence on the part of himself or an agent, where injury results.

The distinction between the administrative and housekeeping functions for which hospitals were traditionally responsible and professional activities for which the physician was responsible has become blurred. Institutional liability for the negligence of its paraprofessional employees, frequently joint liability with independent physicians who are their immediate supervisors, is well settled. The 1965 *Darling* case in Illinois voiced a responsibility of the hospital to review and supervise the care given in a hospital. That case rested in part on the failure of hospital employees in observation and reporting but the principle established was broader. A leading Wisconsin case held a hospital liable for granting staff privileges to an incompetent practitioner. Other cases found liability for the failure of the medical staff to supervise physicians practicing in the institution and for the failure to establish quality review systems. While these all have administrative aspects, they also put the hospitals into potential jeopardy for the quality, or lack of quality, of care provided in the institution. Thus both hospital and physician *could* be liable for concurrent or related acts of negligence which united to cause damage to a patient, or where the negligent acts of the one aggravated the injuries caused by the other party.

Where joint negligence has occurred, the patient may elect to sue the hospital, the physician, or both. If the patient prevails in court against the two, he may enforce his judgment wholly against the hospital or the physician as he may prefer. If there was in fact joint liability of hospital and physician but the patient enforced his judgment against the latter, the physician may then look to the hospital for recovery for such portion of the damages he has paid as represents the hospital's share of the total liability established by the litigation.

As a general proposition the hospital and physician have *separate* legal responsibility to the patient. The former is concerned primarily with safe and adequate facilities and the exercise of a due standard of care in the selection and supervision of its staff and to some extent the care given in the institution. The physician is concerned with the professional care which he either renders or directs on behalf of the patient. While the decisions of various courts furnish numerous instances of suits in which hospital, physician and nurse were jointly sued, it is not uncommon for a court or jury to determine during the course of the trial that no liability exits against one or more of the parties sued. In some cases only the hospital, or the physician or the nurse is found to have been liable in a particular situation. In other cases two of them may be found negligent. In still other cases the suit is dismissed as to all three.

While the functioning of the hospital as an institution and of its nurses and technical staffs with the medical staff call for a high degree of coordination, teamwork and close understanding, all for the benefit of the patient, such facts do *not* of themselves create a joint legal responsibility. Perhaps the best explanation is that while teamwork and cooperation are *practical necessities* they do not automatically create a *joint legal responsibility*. It is up to the patient who asserts negligence to declare whether the hospital, as an administrative institution or as an employer, is responsible for his injury and damage, or whether the physician or others acting under his direction were primarily responsible.

3. What is the extent of legally enforceable rights of a physician against a hospital in which he has staff privileges?

The legally enforceable rights of a physician against a hospital growing out of his staff privileges are relatively limited in character. Thus a staff physician cannot demand that certain managerial policies be adopted, for that is the function of the governing board and its administrator. He cannot demand that the hospital purchase certain equipment, but is entitled to observe that such equipment as it has is inadequate, poorly maintained or unsafe. The latter right grows out of his concern for patient interest and his professional competence to make the observations.

There are two areas worthy of comment in which a staff physician has legally enforceable rights. The first is exemplified in the so-called "inhospital staff specialties" such as radiology, pathology and physiatry. When the medical staff and the governing body of a hospital consider that it is in the public interest, it is lawful for practitioners in these specialties to contract with a hospital to provide consultation services for attending physicians. Such consultants must be members of or acceptable to the medical staff of such hospital. So long as a contract between such a specialist and a hospital relating to his practice is in accordance with the fee splitting statute and other applicable laws, it is enforceable by him against the hospital and by the hospital against him.

The second area of legally enforceable rights enjoyed by staff physicians are those which relate to staff privileges as such. The documents which govern staff privileges are typically bylaws, rules and regulations, the application of an individual physician for staff privileges and the official action on such application, first, by the medical staff, and then by the governing body of the hospital. A physician whose staff appointment is regular in every respect acquires legally enforceable rights once he becomes a member of the medical staff. Those rights depend upon and are limited by the provisions of the hospital bylaws, rules and regulations, and by any particular conditions attached to his appointment, such as limitations on surgical privileges.

It is the proper business of the individual and collective membership of a medical staff to see that the granting of staff privileges, their limitation, suspension and termination are spelled out clearly, adequately and fairly. This is a matter of proper concern to patients whom the physician may hospitalize, and of enlightened self-interest to physician and hospital as well.

There appears to be a trend generally in the courts of this country to recognize something akin to a property right in hospital staff privileges *once they are granted,* so long as they remain in force, and assuming that the physician is not guilty of acts of professional negligence or misconduct. This means that the trend of the courts is away from permitting summary suspension or termination of staff privileges without a fair hearing, except for grave cause which might endanger patients or create liability on the part of the hospital.

Increasing importance should be attached to "negotiations" between the medical staff and the governing body or administrator of a hospital. These can be conducted by the Chief of Staff of a very small hospital, or by the Executive Committee of the medical staff of a larger hospital, in areas in which patient welfare and safety are involved, or in which tensions or conflict may arise between hospital policy and medical policy to the detriment of patient welfare. The latter are not matters of contract right as such, but are akin to "collective bargaining," and become a matter of understanding at the point the hospital and the medical staff are in agreement. They might include such areas as the unwillingness of the governing body of the hospital to follow medical staff recommendations for granting or limiting staff privileges; failure to purchase desirable or needed equipment or to replace equipment in the interests of patient safety or welfare; inadequate selection of the nursing, technical and other staffs of the hospital, or insufficient supervision and continued training during the course of employment. ■

Retention and inspection of patients' records

IT IS GENERALLY agreed that ownership of medical and hospital records rests, respectively, with the physician and the hospital. Their beneficial ownership, that is the right to have them used for one's benefit, is in the patient although the right to possession remains in the physician or hospital. The doctor-patient-hospital relationship has been considered by the legislature and the courts. They have declared it to be in the public interest that the patient have access to relevant records concerning his medical care and treatment.

Because of the long-standing uncertainty regarding the rights of physicians, hospital personnel, patients and others in regard to health care records, efforts both statutory and private have been made to clarify this situation. In 1959 the State Medical Society of Wisconsin and the Wisconsin Hospital Association jointly developed an *Interpretation* seeking to define what is a health record and restate the respective rights of various interested parties in them. This *Interpretation* was printed in the June 1975 Blue Book issue of the *Wisconsin Medical Journal.* (74 *WMJ* 30)

The law under which the *Interpretation* was prepared has been subsequently amended. To the extent of that amendment, the *Interpretation* is no longer valid. It does provide a framework from which to view the issues involved, this framework having been developed jointly by the health professionals most directly involved. The new statute, Sec. 804.10(4), Wis. Stats., is discussed in the box accompanying this article. It deals with authorization by a patient for the examination or inspection of that patient's health care records.

More recently, Secs. 146.81-.83, Wis. Stats., were enacted effective 1980. This new law deals with the release of health care records by consent and without consent. Health care records are defined as "all records related to the health of a patient prepared by or under the supervision of a health care provider." Consent may be given by the patient or one legally permitted to act on the patient's behalf. Consent must contain the name of the patient, the purpose of disclosure of the records, the type of information to be disclosed, the person to whom disclosure may be made, which providers are to make the disclosure, and the time period during which the consent is effective. Access without consent of the patient is permitted for staff, accreditation or review committee use, performance of health care services or consultation regarding them, billing, collecting and payment of claims, on court order, on written request from an appropriate government agency, and for research purposes subject to particular conditions. The new law also covers the subject of patient access to health care records.

Since a patient does have a general right to inspect his medical and hospital records, the question how long to retain records is automatically raised.

A. Retention of Records

For purposes of this article patients can be classified into three legal categories. Each category calls for retention of records for different periods. These are patients (1) over 18 who are mentally competent; (2) over 18 who are mentally ill; and (3) under 18.

Among others, the following reasons for retention of patient records, whether in original or reproduced form, must be considered:

1. To aid medical science; also to facilitate the care of a particular patient who requires treatment or hospitalization at a later time.
2. To provide a record for the assistance of the patient in enforcing his claim for injuries against others than the physician, hospital, or members of their respective staffs.
3. To assist the physician, hospital, a member of the medical or nursing staff, or other personnel in defending against an allegation of negligence made by or on behalf of the patient.
4. To assist the physician or hospital in collecting an unpaid debt due from a patient.

Recommendations

The following recommendations apply to each of the foregoing reasons for retention of records above noted.

1. As to the length of time for retaining records as an aid to medical science or to the patient himself, this will depend in part upon the facilities of the physician's office or the size and character of the hospital and will necessarily involve the judgment of the particular physician or of the medical staff of the hospital. In any event this is a matter of medical judgment and not legal considerations.
2. A mentally normal patient of legal age has *3* years within which to sue *for personal injuries.* If a patient elects to sue on *a contract* rather than for alleged *negligence,* he has *6* years in which to do so. In rare instances which would almost never apply to a patient-physician relationship, he might have up to 20 years. Such

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unusual situations would ordinarily be known to the physician's attorney. To aid the patient in enforcing his claims against others, it is recommended that records be retained for at least 6 years. There is no *legal* requirement for accommodating a former patient longer than the suggested 6 years, although where fraud is alleged, the injured party has 6 years in which to sue *after* discovery of the fraud. For example, a surgeon is chargeable with "fraud" who is aware he has left a foreign object in a patient's body but does not disclose that fact to the patient, or the latter's representative.

3. The period recommended for retention of patient records to defend against an allegation of negligence would depend upon the category into which the patient falls. The principal categories can be summarized as follows:
   A. If the patient is over 18 and mentally competent, the Wisconsin Statutes require that he start an action for alleged negligence within 3 years after the alleged act.
   B. If the patient is over 18 and mentally ill at the time of his treatment or hospitalization, or becomes so within 3 years thereafter, suit must be brought on his behalf, or by him if he recovers, within one year of his recovery, and if he does not recover, within a maximum of 8 years after the alleged negligence.
   C. If the patient is a mentally normal minor at the time of treatment or hospitalization, suit for injuries resulting from alleged malpractice by a health care provider must be brought on behalf of the minor within the later of: (i) 3 years after the injury or (ii) one year from the date the injury was, or should have been, discovered within a maximum of five years after the alleged injury, or (iii) the time the minor reaches the age of 10.
   D. If the patient was a minor and mentally ill at the time of the alleged negligence, and becomes mentally normal by age 18, he must sue for the alleged negligence by the time he is 20, or within three years from the date of the injury, whichever is later. If such patient remains insane after reaching age 18, his guardian must start suit within two years of his recovery, or before the patient is 20, whichever occurs later, all within a maximum of eight years after the alleged negligence.
4. To the extent that patients' records are retained to assist in collection of accounts, such claim must be enforced by the physician or hospital within 6 years of the time it was incurred, unless such time was extended by act of the person owing the account.

An accurate and durable reproduction of the record on microfilm or similar process is as fully admissible before a court as the original itself. *Therefore, the originals of your records, once they are microfilmed, may be destroyed. However, it is advisable to keep the original record for at least 3 years or until the patient has paid your bill.* The reasons for this recommendation are:

1. The original is in many ways more convenient to handle and to read than microfilm;
2. The opportunity for physical examination of an original patient record minimizes the chance of suspicion or an assertion that something is missing.

B. Inspection and Copying of Medical Records:

As a general rule, the right to inspect or copy medical records is based on the consent for such action by the patient or one legally authorized to act for the patient. The issue may arise in any of several situations and in the absence of a statutory exception covering the particular situation the physician should permit inspection and copying of a patient's medical records only by the patient or by one who has a written authorization from the patient (or one legally allowed to act on behalf of the patient) stating the extent of the authorization and describing the records covered by the authorization.

SECTION 804.10(4)

The general rule regarding inspection and copying of medical records is codified in Section 804.10(4), Wisconsin Statutes. It is set out in the box below.

A physician or hospital administrator, and anyone designated by either of them is urged to read this article *before* allowing the inspection or copying of medical records and reports which are in his custody.

STATUTE: 804.10(4)

"804.10(4). Upon receipt of written authorization and consent signed by a person who has been the subject of medical care or treatment, or in case of the death of such person, signed by the personal representative or by the beneficiary of an insurance policy on the person's life, the physician or other person having custody of any medical or hospital records or reports concerning such care or treatment, shall forthwith permit the person designated in such authorization to inspect and copy such records and reports. Any person having custody of such records and reports who unreasonably refuses to comply with such authorization shall be liable to the party seeking the records or reports for the reasonable and necessary costs of enforcing the party's right to discover."

An authorization from or on behalf of a patient allowing the designated person to inspect and copy medical or hospital records or reports concerning the patient's care and treatment may not specify what specific records are covered. The physician on the other hand may have records that go back many years and cover more than one treatment or series of treatments, and more than one illness or hospitalization, or more than one member of a family.

Before complying with the request of a patient to inspect and copy his records, the physician should confer, if practical, with the patient or his representative to ascertain *what* illness, *what* treatment, and *what* period of time are intended by the authorization. If by any chance the records or reports contain material relating to conditions which would be embarrassing to the patient or which might involve other members of the immediate family, the patient or a representative might be very grateful to have the physician point this out and delete them from any preparation.

If practical, the physician might also ascertain who suggested the copying of records. It could be important whether this was another physician, an insurance company, an employer, or an attorney for any such parties.

Some physicians are requesting not only that the time periods to be copied from a medical record or report be specified, but also that each particular illness be specified in the authorization from the patient.

Once the decision has been made how far back to go and just what portions of the total medical record are to be copied, the physician or hospital should *not* let the record leave the premises. For the information of physicians, the statute does *not* authorize the removal of medical or hospital records from the premises. Further, the physician or hospital should *not* permit *anyone* outside the staff to copy the record except in the presence of a staff member.

Whether by intention or not, the physician or hospital might lose a portion of the record if they do not observe these precautions, and such loss could prove a serious handicap later.

Following are some major considerations and safeguards to be observed by a custodian of medical records and reports:

1. Validity of Authorization

Upon being presented with an authorization form for the inspection or copying of medical records and reports, physicians or hospitals must assure themselves that (1) the patient in fact signed the authorization, (2) was of legal age, and (3) had the *mental capacity* to know what he was signing. A minor or incompetent must act through his guardian. Where there is no formal guardianship of a minor, a parent may sign as the natural guardian except where the minor is emancipated as by marriage or self-support.

The physician or hospital must take such precautions as are necessary to satisfy themselves that those designated in the authorization are thereby empowered to inspect and copy the medical records or reports covered by the authorization.

The physician or hospital representatives must also be satisfied that the *person presenting* the authorization to inspect or copy records is the *identical person named* in such instrument. So long as there is any reasonable doubt as to the identity of a person presenting authorization to inspect or copy records, the physician (or his representative) or the hospital (or his representative), depending upon which place the authorization is presented, is warranted in refusing to honor such authorization. The same is true if there is any substantial question as to the authenticity of the signature or the mental capacity or age of the patient.

The statute authorizes the personal representative, or the beneficiary of a life insurance policy, to sign an authorization in case of a patient's death. If you receive such an authorization you can ask the personal representative to provide you with a certified copy of his authority to act. This will take the form of "Domiciliary Letters" or other documentary evidence of appointment or authorization which are issued by the Circuit Court branch handling probate matters.

In the case of the beneficiary of life insurance, you can ask for a certified statement from the insurance company that (1) a policy on the patient was in force at the time of his death, and (2) the person signing the authorization is the beneficiary under the policy.

The burden of proof is on the person seeking the information and the physician has no duty to release such information until he is satisfied that the person asking is so authorized. On being satisfied that the authorization presented is properly signed, as previously outlined, that the person presenting it is the person named therein, and that no question of mental capacity or of minority is involved, it then becomes the duty of the physician or hospital to permit such person to inspect and copy "any medical or hospital records or reports concerning" the care or treatment designated in the authorization. Exactly *what* records and reports may be inspected and copied is discussed in point 2 immediately following.

2. What Can Be Inspected And Copied

It is first necessary to determine what must be made available for inspection and/or copying.

It is believed that under a fair interpretation of subsection (4) the physician's records and reports (office or hospital), and the hospital clinical record or chart should be made available for inspection or copying.

In the case of x-rays there seems to be some disagreement among legal authorities as to whether they are part of the medical record as such, or are technically photographs. It is advised that x-rays be

inspected *only* under proper supervision, in the case of a physician's office by the physician in charge, an associate, or the designee of either, in the case of a hospital or other institution by a qualified physician, or in the event of his unavailability, by a person designated by the administrator.

X-rays must *not* be taken from the office of a physician or other custodian by a patient unless required by a court order or subpoena. When either of the latter is served on the custodian of medical records or reports, Section 804.10(4) *is no longer applicable,* and the authorization is no longer in force.

One of the results of the increasingly comprehensive services of the modern hospital, especially teaching institutions, is the development and maintenance of *two* types of records relating to a patient. One relates directly to his care and treatment, and is the direct professional responsibility of the attending physician and of those acting under him, and may be described as the "official records and reports." The other has sometimes been described as "educational records," which are typically made by nonmedical personnel as part of their training, or at least for purposes not directly related to the "medical care and treatment" of the particular patient.

It is believed that no record or report, other than that made or approved by the physician in charge, or by a consultant, or resident, or by a registered nurse who is recording her/his acts or observations made pursuant to special or standing orders, technically relates to the "medical care or treatment" of the patient, as that phrase is used in the new statute. Nothing but one of the above should be furnished for inspection or copy.

Any *other* writings should be kept *separately* but *not* as a part of the patient's official record, for the reason that the persons making such writings are not professionally responsible for the patient, are not licensed to practice medicine, and are not necessarily recording acts or observations made pursuant to orders of the attending physician. Such writings are not authentic "records" relating to the care of treatment of the patient.

3. Safeguards

The following safeguards are recommended:

(a) Section 804.10(4) does *not* in words or by implication, give a right *to remove* any records from a physician's office, or hospital, the records being the legal property of the physician or hospital.

As an act of prudence, the hospital or physician should require that inspection and copying be carried on *in the presence* of a custodian (hospital or physician), or the representative of either. This statute does *not* require a physician or hospital to copy any records at the request of a patient or his representative. (See below, "Patient Access" under Section 146.83.) If a request is made by a patient or his representative, and the request is granted, the physician or hospital making such copy is entitled to make a reasonable and realistic charge for doing so.

As a precautionary measure to hospital administrative personnel and to physicians, it is suggested that under no circumstances should copies of any medical or hospital records or reports, which are prepared by a representative of the patient, be signed, initialed or subscribed to in any manner that may indicate authenticity and accuracy of such copies.

(b) Few people, other than medically trained personnel, know what is important in a hospital or medical record. For that reason a hospital librarian or other authorized person, or a physician, may in some situations be able to satisfy a request by making inquiry as to what the patient or his representative really wants from the records, and reading the material relative to the inquiry. This may save a great deal of examining, copying, and inconvenience to everyone concerned.

(c) The word "forthwith" used in connection with the right to inspect and copy records does *not* mean "immediately," but as soon as the convenience of a physician, an administrator, or a record librarian, *reasonably* permits, after taking into account the urgency of prior demands on their time and personnel and whether advance notice had been given of the demand of the particular patient.

(d) When there is any indication that legal proceedings may ensue, the physician or hospital served with a proper authorization to examine or copy a patient's records should promptly notify the insurance carrier of this fact, and also the attorney of the physician or hospital. It is recommended that, in the interest of the patient, the hospital, and the physician, the knowledge of any such authorization be given by the person receiving same to the other interested parties.

4. No Authorization Forms Suggested

Since no words appear in Section 804.10(4) prescribing the form of an authorization to inspect and copy a patient's medical or hospital records or reports concerning his care or treatment, model forms are not suggested. (See below the elements of "informed consent.") The observance of the precautions and safeguards emphasized earlier in this article should assure that the patient's interest is protected while at the same time protecting the professional or institutional provider of services.

SECTIONS 146.81-.83

The most important exceptions to the general rule of confidentiality have been collected in Sections 146.81-.83, Wis. Stats. This law, adopted in 1979, defines the essential terms relating to "patient health care records," codifies the right of patients to have access to their records, recognizes the general rule of confidentiality of records, and enumerates the major exceptions to the general rule. A copy of Sections 146.81-.83 appears in boxes on following pages.

146.81 Definitions. In ss. 146.81 to 146.83:

(1) "Health care provider" means a nurse registered or licensed under ch. 441, a chiropractor licensed under ch. 446, a dentist licensed under ch. 447, a physician, podiatrist or physical therapist licensed under ch. 448, an optometrist licensed under ch. 449, a psychologist licensed under ch. 455, a partnership thereof, a corporation therof that provides health care services, an operational cooperative sickness care plan organized under ss. 185.981 to 185.985 that directly provides services through salaried employes in its own facility, or an inpatient health care facility as defined in s. 140.85(1).

(2) "Informed consent" means written consent to the disclosure of information from patient health care records to an individual, agency or organization containing the name of the patient whose record is being disclosed, the purpose of the disclosure, the type of information to be disclosed, the individual, agency or organization to which disclosure may be made, the types of health care providers making the disclosure, the signature of the patient or the person authorized by the patient, the date on which the consent is signed and the time period during which the consent is effective.

(3) "Patient" means a person who receives health care services from a health care provider.

(4) "Patient health care records" means all records related to the health of a patient prepared by or under the supervision of a health care provider, but not those records subject to s. 51.30.

(5) "Person authorized by the patient" means the parent, guardian or legal custodian of a minor patient, as defined in s. 48.02(9) and (11), the guardian of a patient adjudged incompetent, as defined in s. 880.01(3) and (4), the personal representative or spouse of a deceased patient or any person authorized in writing by the patient. If no spouse survives a deceased patient, "person authorized by the patient" also means an adult member of the deceased patient's immediate family, as defined in s. 632.78 (3) (d). A court may appoint a temporary guardian for a patient believed incompetent to consent to the release of records under this section as the person authorized by the patient to decide upon the release of records, if no guardian has been appointed for the patient.

146.815 Contents of certain patient health care records

(1) Patient health care records maintained for hospital inpatients shall include, if obtainable, the inpatient's occupation and the industry in which the inpatient is employed at the time of admission, plus the inpatient's usual occupation.

(2) (a) If a hospital inpatient's health problems may be related to the inpatient's occupation or past occupations, the inpatient's physician shall ensure that the inpatient's health care record contains available information from the patient or family about these occupations and any potential health hazards related to these occupations.

(b) If a hospital inpatient's problems may be related to the occupation or past occupations of the inpatient's parents, the inpatient's physician shall ensure that the inpatient's health care record contains available information from the patient or family about these occupations and any potential health hazards related to these occupations.

(3) The department shall provide forms that may be used to record information specified under sub. (2) and shall provide guidelines for determining whether to prepare the occupational history required under sub. (2). Nothing in this section shall be construed to require a hospital or physician to collect information required in this section from or about a patient who chooses not to divulge such information.

146.82 Confidentiality of patient health care records.

(1) CONFIDENTIALITY. All patient health care records shall remain confidential. Patient health care records may be released only to the persons designated in this section or to other persons with the informed consent of the patient or of a person authorized by the patient.

(2) ACCESS WITHOUT INFORMED CONSENT. (a) Notwithstanding sub. (1), patient health care records shall be released upon request without informed consent in the following circumstances:

1. To health care facility staff committees, or accreditation or health care services review organizations for the purposes of conducting management audits, financial audits, program monitoring and evaluation, health care services reviews or accreditation.

2. To the extent that performance of their duties requires access to the records, to a health care provider or any person acting under the supervision of a health care provider or to a person licensed under s. 146.35 or 146.50, including but not limited to medical staff members, employes or persons serving in training programs or participating in volunteer programs and affiliated with the health care provider, if:

a. The person is rendering assistance to the patient;

b. The person is being consulted regarding the health of the patient; or

c. The life or health of the patient appears to be in danger and the information contained in the patient health care records may aid the person in rendering assistance.

3. To the extent that the records are needed for billing, collection or payment of claims.

4. Under a lawful order of a court of record.

5. In response to a written request by any federal or state governmental agency to perform a legally authorized function, including but not limited to management audits, financial audits,

continued on next page

1. Definitions

The statutory definitions of "health care provider," "Patient," and "patient health care records" are virtually all inclusive. Section 146.81, Wis. Stats. The law is intended to cover all health records of all patients of all providers.

In addition the law defines "informed consent." This is the statutory equivalent of the authorization referred to above. It means the *written* consent for disclosure of information from a patient's health care records and must include: the patient's name, the purpose for disclosure of the information, the type of information to be disclosed, to whom disclosure may be made, what providers must make the disclosure, the date of the consent, the period during which the disclosure consent is effective, and the signature of the patient or the "person authorized by the patient" (also a defined term).

As defined, "informed consent" is more specific and detailed than general authorization for inspection and copying records as discussed above. Because of the inclusive wording of the definitions it can be argued that all releases of information from health records are subject to this part of the law, notwithstanding the different phrasing of Section 804.10(4). For safety's sake it would be well to insist that any consent or authorization meet the standards of Section 146.81.

Other inconsistencies between the definitions in Sections 146.81 and 804.10(4) are relatively minor but may be significant in particular situations (e.g., disclosure of information from the records of a deceased patient).

2. Occupational Health

Physicians under Section 146.815 are to ensure that a hospitalized patient's records contain available information on the patient's occupation and health hazards related to it if the condition being treated may be occupation related. Information on the occupation of a patient's parents must also be included if relevant to the condition of the patient.

The responsibility under this section of the law is imposed on physicians but this information does not have to be obtained from any patient who refuses to disclose it.

3. Statutory Exceptions

The general rule of confidentiality of patient records is reiterated in Section 146.82. Following that statement the law lists six situations in which information from a patient's health care records may be released without informed consent. These include: management, financial, and service audits and accreditation; treatment or consultation regarding treatment of the patient; billing and collection of claims; under court order; government investigations; and research, where the product of this research will not identify individual patients. As to the last two (government investigation and research) private pay patients may deny access to their records by executing a form provided by the Depart-

continued from preceding page

program monitoring and evaluation, facility licensure or certification or individual licensure or certification. The private pay patient may deny access granted under this subdivision by annually submitting to the health care provider a signed, written request on a form provided by the department. The provider, if a hospital or nursing home, shall submit a copy of the signed form to the patient's physician.

6. For purposes of research if the researcher is affiliated with the health care provider and provides written assurances to the custodian of the patient health care records that the information will be used only for the purposes for which it is provided to the researcher, the information will not be released to a person not connected with the study, and the final product of the research will not reveal information that may serve to identify the patient whose records are being released under this paragraph without the informed consent of the patient. The private pay patient may deny access granted under this subdivision by annually submitting to the health care provider a signed, written request on a form provided by the department.

(b) Unless authorized by a court of record, the recipient of any information under par. (a) shall keep the information confidential and may not disclose identifying information about the patient whose patient health care records are released.

146.83 Patient access to health care records.

(1) Except as provided in s. 51.30 or 146.82 (2), any patient or other person may, upon submitting a statement of informed consent:

(a) Inspect the health care records of a health care provider pertaining to that patient at any time during regular business hours, upon reasonable notice.

(b) Receive a copy of the patient's health care records upon payment of reasonable costs.

(c) Receive a copy of the health care provider's X-ray reports or have the X-rays referred to another health care provider of the patient's choice upon payment of reasonable costs.

(2) The health care provider shall provide each patient with a statement paraphrasing the provisions of this section either upon admission to an inpatient health care facility, as defined in s. 140.85 (1), or upon the first provision of services by the health care provider after April 30, 1980.

(3) The health care provider shall note the time and date of each request by a patient or person authorized by the patient to inspect the patient's health care records, the name of the inspecting person, the time and date of inspection and identify the records released for inspection.

ment of Health and Human Services. (This form was not available for several months after the law became effective.) Anyone obtaining information under these exceptions may not, without court authority, disclose the information received.

Perhaps the most critical exception deals with governmental investigations. This includes the investigation of complaints by license law agencies. This exception exists if there is a written request by the agency and it is to assist it in performing a legally authorized function. The power to compel disclosure is conditioned upon the agency complying precisely with the law. If a physician receives such a request, care should be exercised to determine that it meets the requirements of the statute since this is an exception to the general rule of confidentiality.

Where the governmental investigation is being conducted to ascertain whether a physician has been guilty of unprofessional conduct, an administrative rule of the Medical Examining Board, Med 12.03(1), must be considered to determine whether the agency's powers are being lawfully exercised. This rule, which establishes the Examining Board's investigative procedures, permits such investigations to be conducted by an agent of the Examining Board acting under the supervision and direction of the secretary or another member of the Examining Board. There is some conflict in the law between the powers of the Examining Board and the Department of Regulation and Licensing in investigative matters but any investigation conducted under the authority of the Examining Board must meet its standards.

CONSENT TO RELEASE MEDICAL INFORMATION

I, _____ do hereby
(name of patient)

consent to and authorize _____,
(name of physician or health care institution)

to disclose to _____
(specific individual or organization)

information from my medical records relating to my identity, diagnosis, prognosis or treatment compiled during my medical treatment(s)/hospitalization from _____ (date) to _____ (date). I understand

that the specific type of information to be disclosed includes: _____

_____

I understand that this consent may be revoked except to the extent that action has already been taken in reliance thereon, and that this authorization for disclosure will be effective until:

_____
(time or condition)

_____
Signature of Patient . . . . . OR

_____
Person Authorized by the Patient* and

_____
his/her relationship to patient

_____
Witness

Dated this _____ day of _____, 19____.

NOTE TO RECIPIENT OF INFORMATION. This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosure of this information without the specific written consent of the patient or legal representative involved.

*NOTE: Person authorized by the patient means the parent, guardian, or legal custodian of a minor patient or a patient adjudged incompetent; the spouse or personal representative of a deceased patient; or any person authorized in writing by the patient which is witnessed and dated.

4. Patient Access

The law also addresses patient access to health records. Section 146.83, Wis. Stats. A patient or one with a patient's "informed consent" may inspect that patient's records at reasonable times, obtain copies of these records upon payment of reasonable costs, and receive copies of X-ray reports or have the X-rays referred, also upon payment of reasonable costs.

Physicians providing first services to a patient after April 30, 1980, are to provide a statement paraphrasing patient access rights to the patient. Physicians are to keep a log of patient access requests by time and date, person authorized to inspect the records, time and date of inspection, and identity of records inspected. ■

Patients' right of access to their medical records

A notice, which explains to patients the law requiring all physicians and hospitals to advise their patients of the patient's right of access to their medical record, is available to Society members for posting in their offices at a place easily seen by all patients. Patients may receive information from their record upon completion of an "informed consent" release form (see copy at left). Write: State Medical Society of Wisconsin, Attn: Communications Coordinator, PO Box 1109, Madison, Wisconsin 53701; or phone (608) 257-6781 Madison area or 1-800-362-9080 in Wisconsin. ■

"DENIAL OF ACCESS" FORMS. These forms are provided by the State Department of Health and Social Services and can be *purchased from the Document Sales Office, Department of Administration, PO Box 7840, Madison, Wis 53707; or phone (608) 266-3358.* (They are *not* available through the DHSS or the State Medical Society.) Forms come in packages of 125 for $12.50 or 25 for $5.00. (See sample copies adjacent.)■

Denial of Researcher Access to Health Care Records

(Private Pay Patients Only)

State of Wisconsin, Department of Health & Social Services, HSS-0003

Patient's Name
Patient's Birthdate
Health Care Provider

Completion of this form is entirely optional. You do not have to sign this form to receive care or services. Please read the following points before deciding whether you wish to sign.

1) In order to perform studies of health care, researchers affiliated with your health care provider may wish to review your health care records. These researchers have a legal duty to keep your identity confidential and to make sure that information from your health care records is not given to anyone who is not connected with the research.
2) State law says that a private pay patient may choose to keep researchers from reviewing his or her health care records; this may be done by signing the Denial of Researcher Access statement below. Please feel free to discuss this matter with family, friends or an attorney.
3) If you decide to sign this form, you will need to sign a new form each year that you wish to deny access to your records.
4) If you sign this form and later change your mind and decide to let researchers review your health care records, you may cancel the Denial of Researcher Access statement below at any time by signing a written cancellation statement and giving it to your health care provider.

DENIAL OF RESEARCHER ACCESS TO HEALTH CARE RECORDS
(Private Pay Patients Only)

I have read the above information and understand that I do not have to sign this form to receive health care services. I understand that by signing this form, I will keep researchers from reviewing my health care records for a period of one year from the day I sign it. I also understand that I may cancel this statement at any time by signing a written cancellation statement. (S. 146.82 (2) (a) 6., Stats.)

Signature of Patient
(or Legal Guardian) _____ Date _____

Denial of Government Access to Health Care Records

(Private Pay Patients Only)

State of Wisconsin, Department of Health & Social Services, HSS-0002

Patient's Name
Patient's Birthdate
Health Care Provider

Completion of this form is entirely optional. You do not have to sign this form to receive care or services. Please read the following points before deciding whether you wish to sign.

1) State and federal law directs government agencies to make sure that doctors, nurses, hospitals, nursing homes and other health care providers give health care of good quality in a safe setting and protect patient rights.
2) To make sure that health care services meet the basic legal requirements, state and federal agencies may need to review patient health care records. These records tell agencies how patients have been treated and can be very important during any investigation of alleged poor care, patient abuse, fraud, or patient rights violations. These agencies have a legal duty to keep the records they review confidential.
3) State law says that a private pay patient may choose to keep state and federal agencies from reviewing his or her health care records; this may be done by signing the Denial of Government Access statement below. Please feel free to discuss this matter with family, friends or an attorney.
4) If you decide to sign this form, you will need to sign a new form each year that you wish to deny access to your records.
5) If you sign this form and later change your mind and decide to let state and federal agencies review your health care records, you may cancel the Denial of Government Access statement below at any time by signing the Cancellation Statement on the back of your copy of this form or your own cancellation statement and giving it to your health care provider.

DENIAL OF GOVERNMENT ACCESS TO HEALTH CARE RECORDS
(Private Pay Patients Only)

I have read the above information and understand that I do not have to sign this form to receive health care services. I understand that by signing this form, I will keep state and federal agencies from reviewing my health care records for a period of one year from the day I sign it. I also understand that I may cancel this statement at any time by signing the statement on the back of this copy or my own cancellation statement. (S.146.82(2)(a)5., Stats.)

Signature of Patient
(or Legal Guardian) _____ Date _____

(Note: If you are in a hospital or nursing home, a copy of this form will be sent to your private physician once it is signed.)

The use of consent and related forms for physicians

PREFACE

The forms referred to in this article are those which a physician may have occasion to use in his regular everyday practice. Since the forms were printed in the January 1970 "Blue Book" issue of the *Wisconsin Medical Journal,* they will not be reprinted here except for a few examples. Any physician wishing "sample" copies of these forms may obtain them upon request to the State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701; or telephone 257-6781 in the Madison area or toll-free in Wisconsin 1-800-362-9080. These forms will frequently need to be adapted for a particular situation. Each physician should review them carefully before using them to make sure that they reflect the realities of a specific situation.

The forms, as printed in the January 1970 "Blue Book" issue and as listed in the box below, and the text in this article have been prepared by legal counsel for the State Medical Society of Wisconsin, and reflect changes in the laws and courts in Wisconsin since the previous publication in January 1970.

The forms listed in the box below do not cover every possible situation where a consent should be obtained. Additional forms are contained in a publication of the American Medical Association called *Medico-legal Forms with Legal Analysis, 1976.* The Society attorneys suggest that any forms that a physician might wish to use outside of the forms referred to in this article be checked with the physician's personal attorney to determine their legal adequacy.

Finally, the forms do not cover those procedures which are normally done in a hospital. The Wisconsin Hospital Association has a publication entitled *Consent Manual.*

CONSENT FORMS FOR PHYSICIANS

FORMS WHICH A PHYSICIAN may have occasion to use in his regular everyday practice were printed in the January 1970 "Blue Book" issue of the WISCONSIN MEDICAL JOURNAL, and, therefore will not be reprinted here. Any physician wishing "sample" copies of these forms may obtain them upon request to the *Wisconsin Medical Journal,* Box 1109, Madison, Wisconsin 53701; or tel. 608/257-6781. (Member physicians in Wisconsin may dial toll-free number: 1-800-362-9080.) Form numbers and titles as they appeared in 1970 are listed below for easy reference when requesting such forms. These forms will frequently need to be adapted for a particular situation. Each physician should read them carefully before using them to make sure that they reflect the realities of a specific situation.

Form 1: Letter to former patient where physician does not wish to treat later illness.
Form 2: Authorization to disclose information to new physician.
Form 3: Letter of withdrawal from case.
Form 4: Letter to confirm discharge by patient.
Form 5: Letter to patient who fails to follow advice.
Form 6: Letter to patient who fails to keep appointment.
Form 7: Statement of patient leaving hospital against medical advice.
Form 8: Provision for substitute physician at delivery.
Form 9: Consent to office treatment.
Form 10: Consent to examination of physician's records.
Form 11: Consent to taking of photographs.
Form 12: Consent to publication of photographs.
Form 13: Authority to admit observers.
Form 14: Consent to taking of motion pictures of operation.
Form 15: Consent to televising of operation.
Form 16: Statement of need for therapeutic abortion.
Form 17: Authorization to treat condition of recent or partial abortion.
Form 18: Artificial insemination homologous consent.
Form 19: Aid consent.
Form 20: Aid donor consent.
Form 21: Aid donor's wife consent.
Form 22: Consent to sterilization as a result of operation.
Form 23: Consent to therapeutic sterilization.
Form 24: Consent to non-therapeutic sterilization.
Form 25: General consent to operation.
Form 26: Consent to operation.
Form 27: Consent to operation for cosmetic purposes.
Form 28: Consent to removal of tissue for grafting.
Form 29: Consent to operation and grafting of tissue.
Form 30: Order for taking of x-ray films.
Form 31: Consent to x-ray therapy.
Form 32: Permission to use radioisotopes.
Form 33: Consent to diagnostic procedure.
Form 34: Agreement for blood transfusion.
Form 35: Agreement for blood plasma transfusion.
Form 36: Agreement with blood donor.
Form 37: Release and receipt (blood donor).
Form 38: Agreement with blood donor.
Form 39: Release and receipt (blood donor).
Form 40: Consent to disposal of amputated part of organ.
Form 41: Gift of part of body under Wisconsin Uniform Anatomical Gift Act of 1969.
Form 42: Authorization for tissue donation.
Form 43: Authorization for autopsy and tissue donation.
Form 44: Authorization for autopsy.
Form 45: Consent to disposal of dead fetus.

All member hospitals of that Association have the manual. Those forms cover hospital situations, whereas this article is concerned primarily with the physician in his regular practice.

I. What is consent

Consent, in the context that we are using it, means permission from a patient or his legal representative, to a physician to diagnose and treat the patient.

a. Informed consent

To be legally valid, consent must be given by the appropriate person (see II. *Who Can Consent,* below) and this consent must be given with appropriate understanding of the nature of the treatment and the risks associated with it. This has been the law of the United States and Wisconsin for many years; and the courts have held the physician liable for treatment without proper consent, even when the treatment worked and the results were good. Treatment without consent is actionable and is the easiest form of suit against a physician because no expert testimony or evidence is needed and historically the burden has been on the physician to prove that he or she proceeded only with proper patient consent.

Under Wisconsin law you must disclose to the person giving consent such information as is necessary under the circumstances to enable a reasonable person under those circumstances to intelligently exercise his right to consent to or refuse treatment. The disclosure must be made in terms understandable to the person giving consent and need not include disclosure of matters already known to the person or risks which are extremely remote possibilities.

This rule leaves broad areas of professional judgment to the physician but requires disclosure of all matters that would be relevant to a reasonable person to permit him to make an intelligent decision to consent to or refuse the recommended treatment.

In addition a new Wisconsin law requires that the patient be informed about available alternate methods of treatment (see adjacent box).

The forms, as printed in January 1970, and other standard forms which you may use generally do not provide for a full description of the disclosures given, either as to treatment or risks involved. You should make some provision in your patient records to indicate specifically what disclosures were made. Some physicians tape record their disclosures and retain these tapes with the patient records. Some who are involved in the same procedure frequently use prepared statements covering the treatment and its risks and obtain receipts for copies of this information. Some give disclosures in front of witnesses and have their notes on the matters disclosed initialed or countersigned by the witnesses. For your protection you should have some record of the matters disclosed in each situation.

b. Implied consent

There are situations where the consent of the patient does not have to be in writing or even expressed orally. This is implied consent.

A classic example of implied consent is the unconscious victim of an automobile accident where immediate action needs to be taken to save the life of the patient or at least to minimize the effect of his injuries. In this emergency situation consent is implied. The courts say that if the patient had been conscious he would have given consent to

Chapter 375, Laws of 1981

AN ACT to amend 448.02(3) (intro.) and 448.40; and to create 448.30 of the statutes, relating to requiring physicians to inform their patients of alternate modes of treatment, granting rule-making authority and creating a penalty.

448.02(3) Investigation; hearing; action. (intro.) The board shall investigate allegations of unprofessional conduct by persons holding a license or certificate granted by the board. A finding by a panel established under s. 655.02 or by a court that a physician has acted negligently is an allegation of unprofessional conduct. *An allegation that a physician has violated s. 448.30 is an allegation of unprofessional conduct.* After the investigation, if the board finds that there is probable cause to believe that the person is guilty of unprofessional conduct, the board shall hold a hearing on such conduct. The board may, when it finds a person guilty of unprofessional conduct, warn or reprimand that person, or limit, suspend or revoke any license or certificate granted by the board to that person. The board shall comply with rules of procedure for such investigation, hearing and action promulgated under s. 440.03(1).

448.30 Information on alternate modes of treatment. Any physician who treats a patient shall inform the patient about the availability of all alternate, viable medical modes of treatment and about the benefits and risks of these treatments. The physician's duty to inform the patient under this section does not require disclosure of:

(1) Information beyond what a reasonably well-qualified physician in a similar medical classification would know.
(2) Detailed technical information that in all probability a patient would not understand.
(3) Risks apparent or known to the patient.
(4) Extremely remote possibilities that might falsely or detrimentally alarm the patient.
(5) Information in emergencies where failure to provide treatment would be more harmful to the patient than treatment.
(6) Information in cases where the patient is incapable of consenting.

448.40 Rules. The board may adopt rules pursuant to ch. 227 to carry out the purposes of this chapter. *The board shall adopt rules to implement s. 448.30.*

save his life and, therefore, the physician will not be penalized for doing what he would have been allowed to do if the patient had been conscious.

II. Who can consent

Persons who are adults and are competent to understand what the physician is proposing to do, why it is necessary or desirable, and what the risks of doing it are going to be, can give a consent.

a. Minors

In Wisconsin, persons under the age of 18 are minors.

The proper person to consent to surgery or other treatment of a minor is either parent, or if neither parent is living, the minor's court appointed guardian. A physician is not legally protected by a consent signed by a relative of a minor, other than a parent, unless the relative has been appointed as the minor's legal guardian by a court.

There are two exceptions to the above general rule. First, in an emergency, a consent is not necessary if the parents or guardian cannot be located, and, in the judgment of the physician in charge and, of consultants where consultation is practical, immediate treatment is necessary to save life or to prevent the deterioration or aggravation of the condition of the patient.

The legal reason for the above exception is that in an emergency the law implies the consent of the patient, or in the case of a minor, of his parent or guardian. Because the law does not imply consent beyond the treatment actually necessary to meet an emergency, the physician may safely treat only the emergency condition itself, and nothing else, without actual consent of a parent or guardian.

Second, an emancipated minor can give a consent for medical treatment, including surgery. A minor is emancipated (1) who is lawfully married, or (2) whose parents have divested themselves of their legal right of control over him. Typically a minor in the latter situation is one who is self-supporting. An unmarried minor attending school away from his home community is not emancipated by virtue of that fact alone.

A physician who has any doubt whether a minor is emancipated, should require the consent of a parent or the legal guardian before proceeding with non-emergency treatment.

b. Incompetents

Physicians, above all others, are qualified to determine whether a person is competent to sign a consent. If a patient is incompetent, a consent by the patient will not be any protection. For incompetents other than minors, consent can only be given by the person's legally appointed guardian, except in emergencies. Courts in Wisconsin have very limited powers to substitute their discretion for that of a person's legally appointed guardian.

c. Persons under the influence of of drugs or intoxicants

Unless there is an emergency situation, the physician should either wait until the influence of the drug or intoxicant passes, or, make appropriate contacts for the appointment of a guardian. In the case of an emergency, treatment necessary to save life can be given.

MINOR'S CONSENT

A common question from physicians throughout the state is under what circumstances may a physician provide medical services to a minor without parental consent.

As a general rule, consent for medical services to be provided to an unemancipated minor must be given by the minor's parent, guardian, or court-appointed sustaining parent. Under appropriate circumstances a court may give consent in lieu of a parent.

Emancipation occurs when a minor is no longer under parental care and custody. A common example of emancipation is marriage by a minor.

Wisconsin law also provides that a minor may receive diagnosis of and treatment for venereal disease and drug abuse without parental consent. Attempts to expand this law to include all medical care have failed.

This area of the law, parental rights versus minors' right of privacy, is now quite active and physicians should be alert to rulings which bear on this conflict.

III. Why consents

In Wisconsin failure to obtain informed consent for medical treatment is the negligent violation of a legal duty. As a result of this, a physician may be sued for a species of malpractice. In other states, and under earlier case law in Wisconsin, treatment without consent was treated as a form of assault and subject to civil, and possibly criminal, liability on that basis. It is possible that in an aggravated situation, where the physician has obtained no consent or where his treatment has gone beyond the consent given, courts would still act on the assault rather than the negligence basis. In most cases, however, it should be anticipated that the question will be whether informed consent was given and failure of the physician to obtain consent based on an adequate explanation of the treatment and its possible risks is a form of negligent malpractice.

In an action for failure of informed consent, the patient has the responsibility of proving failure of disclosure by the physician, lack of knowledge by the patient of the

nature of the treatment and its risks, and the adverse effects of the treatment. The physician, by way of defense, may prove reasons why no disclosure was given, these defenses to be based on the "reasonable person" rule discussed above. No expert testimony is required to assist the jury in determining whether the failure of disclosure led to consent to the treatment, or phrased another way, whether adequate disclosure would have resulted in the patient's refusing the treatment.

A few minutes spent preparing, explaining, and obtaining the consent signed by the patient and making appropriate notes in the patient records can save untold hours of time, money, and embarrassment for the physician.

IV. Consents limited

A word of caution needs to be set forth. A valid consent must not be too broad. It cannot be a general consent for the physician to do anything he wants to do. It should be limited to the specific situation presented by the diagnosis of the patient's illness. Finally, a consent is not effective if the treatment or procedure consented to is illegal, is contrary to public policy or, is given by a person who had no legal right to give it.

V. Consent and related forms

The text and suggestions that follow are related to the numbered forms as printed in the January 1970 "Blue Book" and as listed in the box on page 20. Physicians should read the text and suggestions prior to attempting to use or adapt a particular form.

PHYSICIAN AND PATIENT

1. Contract for services

The physician-patient contract is established when the physician, in response to an express or implied request to treat the patient, undertakes to render professional services to him. It is not necessary to have a formal written contract. The contract between the patient and physician is implied and is enforceable. If you wish, you may restrict your services to one procedure, one treatment or treatments at a particular time or place. This can be done by a letter requesting the patient to sign and return a copy to you. No form has been included for this situation. A physician need not accept every person who wishes services. He can accept patients as he wishes. Further, specialists need not accept patients who have illnesses outside their specialty.

However, once the patient-physician relationship has been entered into the physician is under an obligation to treat the patient until the relationship is terminated.

"LIVING WILL" ON USE OF MEASURES TO SUSTAIN LIFE

Many people express their desire that no "heroic" measures be used to sustain their physical functions if this would result in their being totally incapacitated, comatose, or otherwise severely impaired. Various forms of a "living will," purporting to direct the scope of care to be given or withheld in such situations have been prepared and are in circulation.

It is unlikely that any of these documents can adequately address the complex medical judgments in a particular case but they do offer some guidance on the attitude of a patient who may no longer be able to speak for himself. It remains for serious and considered ethical and professional evaluation to see how and if the expressed attitude can be reflected in the management of the patient. ■

BRAIN DEATH

A new Wisconsin law (Chapter 134, Laws of 1981) provides that 146.71 of the statutes is created to read: **Determination of death.** An individual who has sustained either irreversible cessation of circulatory and respiratory functions or irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death shall be made in accordance with accepted medical standards. ■

AUTOPSY

Question: Whose consent is required to permit a physician to conduct an autopsy?

Answer: Except for those cases in which an autopsy is ordered in connection with a proposed coroner's inquest, permission for a physician to conduct a post mortem examination requires the consent of the person who assumes custody of the body for burial, providing he is one of the following: father, mother, husband, wife, child, guardian, or next of kin. If none of these is available, consent may be given by a friend or person charged by law with the responsibility for burial. If two or more such persons assume custody of the body, the consent of either one is sufficient.

Section 979.125, Wisconsin Statutes, requires autopsies for infant death in which "sudden infant death syndrome" is suspected, unless the parents specifically object. ■

2. Termination of contract

Care must be taken to inform the patient appropriately, but unmistakably when the patient-physician relationship is terminated. What should be done depends upon how the situation arises.

a. Former patient

If you have a former patient who calls and wishes further services, and you do not wish to further treat that patient, you should make your decision clear. Following such conversation you should confirm it by a letter. Form 1, with its enclosure, Form 2, is appropriate and gives the physician a record for his file. (These forms appear as "examples" on page 26.)

b. Withdrawal from a case

There may be occasions where a physician does not wish to continue on a case. Consistent with legal as well as ethical principles he must find appropriate steps to withdraw. He cannot just stay away and not notify the patient. This would be abandoning the patient and could subject the physician to a suit for damages.

FORM 1

LETTER TO FORMER PATIENT WHERE PHYSICIAN DOES NOT WISH TO TREAT LATER ILLNESS

Dear _____:

This letter is to confirm our conversation of _____ _____ (date).

At that time I informed you that I could not accept you as a patient for your present illness. I suggested to you that you contact another physician and I urge you to do so now if you have not already done so.

Since I have treated you for a previous condition, I have records which your new physician can use. Upon receipt of your written approval, I will make available to your new physician your case history and complete information regarding the diagnosis and treatment which you have received from me.

For your convenience I enclose a form that you may use to give me such written approval.

Very truly yours,

_____M.D.

(Enclose Form 2)

FORM 2

AUTHORIZATION TO DISCLOSE INFORMATION TO NEW PHYSICIAN

I authorize _____, M.D., my former physician, to disclose complete information to my present physician, _____, M.D., concerning medical findings and treatment from about _____ 19____ until the date of this authorization.

Signed _____

Place _____

Date_____

Witness _____

Witness _____

He must give the patient proper notice that he is withdrawing from the case and must give the patient a reasonable amount of time to obtain a new physician. What is a reasonable amount of time will depend upon the circumstances of the case and the availability of other physicians in the area. We suggest that under most circumstances that the time set forth be not less than five (5) days. To provide a record and protect the physician a letter should be sent to the patient. If the letter is sent by certified mail with a return receipt requested, the physician will have record in his file showing not only that the patient was notified, but also the date the patient received the notification. Form 3 (example on page 26) is appropriate for this purpose. We suggest that you may wish to enclose Form 2 with the letter for the patient's convenience.

c. Discharge of a physician

The patient may also terminate the contract by discharging the physician. The physician will want to make an immediate and adequate record that he did not abandon the patient. The physician may do well to try to obtain from the patient a signed statement of the facts and discharge of the physician. Where this is not available we suggest that the physician send a letter to the patient such as Form 4. Again, the enclosure of Form 2 is appropriate. We suggest the letter be sent by certified mail, with a return receipt requested so that your file will show receipt of the letter by the patient.

3. Special problems during treatment

There are many problems that can arise during the treatment of a patient. The ones covered in this section are of particular importance to the physician since, if no pro-

FORM 3

LETTER OF WITHDRAWAL FROM CASE

Dear Mr. _____:

I find it necessary to inform you that I am withdrawing from further professional attendance upon you for the reason that you have persisted in refusing to follow my medical advice and treatment.

Since your condition requires medical attention, I suggest that you place yourself under the care of another physician without delay. If you so desire, I shall be available professionally to attend you for a reasonable time after you have received this letter, either for regular or emergency medical treatment, but in no event for more than _____ days following such receipt. This should give you ample time to select a physician of your choice from the many competent practitioners in this area.

With your written approval, I will make available to this physician your case history and complete information regarding the diagnosis and treatment which you have received from me.

Very truly yours,

_____, M.D.

Enclosure Form 2

tective steps are taken and a record made of such steps, the defense against allegations of malpractice could be made considerably harder and more expensive.

a. Patient who fails to follow advice

Where a physician feels that a certain treatment or procedure should be done and the patient refuses, a record should be made. Form 5 may be adapted to the situation as it occurs.

b. Patient who fails to keep appointment

If a patient fails to keep an appointment where the patient has a condition the physician knows needs treatment, the physician should make this fact known to the patient. The physician, at the same time, should see that his records reflect his professional advice to the patient. A letter such as Form 6 should be sent to the patient.

c. Patient who leaves hospital against medical advice

Cases arise where patients refuse to remain in a hospital even though their physician feels that continued hospitalization is necessary. Form 7 (example on page 27) provides a statement that the patient may sign which will release liability for the patient's acts. The physician should have two witnesses with him at the time he informs the patient of the reasons the physician feels indicate the need for continued hospitalization. These witnesses should sign the form whether the patient signs the form or not. If the patient refuses to sign, that fact should be noted on the form. The physician should have a copy of the form for his office records. The hospital will also want a copy for its records.

d. Substitute physician in obstetrical cases

It is not unusual for a physician to be unable to be present at a delivery, even though the physician would wish to be there. Another delivery might be in progress or the speed of delivery might make it impossible for the physician to get to the place of delivery. The physician should explain this to his obstetrical patient when she first comes to his office. The physician should have the expectant mother sign a form such as Form 8 as an acknowledgment of the fact that she understands and agrees.

e. Office treatment

Some procedures can be done either in the physician's office or in the hospital. Where the physician decides to do the procedure in his office he should inform the patient of the alternatives and any special risks involved. If the patient decides that the procedure should be done in the hospital, the physician should not attempt to do the procedure in his office. If the patient does agree to having the procedure in the office, then the physician should have the patient sign a consent such as Form 9.

4. Confidential and privileged relationship

In Wisconsin, communications between a patient and his physician are protected both by law and ethics.

Under Wisconsin law, certain disclosures made by a patient to his physician in order to give the physician sufficient information to enable him to treat the patient are "privileged." This "privilege" means that the statements cannot be disclosed by the physician unless the patient allows it or unless the physician is allowed or required by law to disclose them. The "privilege" is that of the patient, and can ordinarily be claimed or released only by the patient.

Confidential communications involve a physician's ethical duty to keep secret the information he has obtained about a patient while acting in his professional capacity. This obligation is independent of the privilege discussed in the preceding paragraph. It is binding on the physician at all times.

Wisconsin Statutes permit the right of an employee or the employee's designated representative to inspect personal medical records concerning the employee contained in the employer's file. If the employer believes that disclosure of an employee's medical records would have a detrimental effect on the employee, the employer may release the medical records to the employee's physician or through a physician designated by the employee, in which case the physician may release the medical records to the employee's immediate family.

Unauthorized disclosure of confidential information can be grounds for revocation of the physician's license. It may also be the basis for a suit for damages by the patient. Each physician therefore must exercise care to protect against unauthorized disclosure of confidential or privileged information.

FORM 7

STATEMENT OF PATIENT LEAVING HOSPITAL AGAINST MEDICAL ADVICE

This is to certify that I am leaving _____ Hospital at my own insistence and against the advice of my attending physician and hospital authorities. I have been informed by them of the dangers attendant on my leaving the hospital at this time. I assume all responsibility for any results caused by leaving the hospital prematurely, and I hereby release my attending physician and the hospital, its employees and officers from all liability for any and all conditions, complications and results.

_____

I hereby agree to hold harmless my attending physician and the _____ Hospital, its employees and officers, from all liability of whatsoever nature, with reference to the discharge of the patient named above.

_____

(husband, wife, parent, etc.)

Date _____

Signed in the presence of:

Witness _____

Witness _____

NOTE: If the patient refuses to sign such a statement, he cannot be forced to do so, legally, nor may his release be withheld until he signs. If this occurs, the form should be filled out, witnessed by the hospital personnel present, and the statement made on the form "signature refused."

a. Release of patient health care records

By earlier case law and now by statute, a patient's health care records (all records related to the health of a patient prepared by or under the supervision of a health care provider) may ordinarily only be released on the authorization of the patient or one legally permitted to act for the patient. The law defines "informed consent" with respect to the disclosure of information from a patient as written consent "containing the name of the patient whose record is being disclosed, the purpose of the disclosure, the type of information to be disclosed, the individual, agency or organization to which disclosure may be made, the type of health care providers making the disclosure, the signature of the patient or the person authorized by the patient, the date on which the consent is signed and the time period during which the consent is effective." Wis. Stats. §146.81 (2). In making a release of medical records, the physician should very carefully review the authorization to assure that the release is made strictly in accordance with the authorization.

(1) Access without informed consent. Release of medical records without patient authorization, unless specifically permitted by law, is a breach of confidentiality and may subject the physician to a lawsuit. The law permits the release of patient health care records upon request without informed consent in the following circumstances:

(a) To staff, accreditation or review committees.

(b) For performance of health care services to persons providing such services (including emergency care) or being consulted in regard to such services.

(c) For billing, collection, and payment of claims.

(d) Under court order.

(e) On written request from an appropriate government agency.

(f) For research purposes under specific conditions.

FORM 16

STATEMENT OF NEED FOR THERAPEUTIC ABORTION

We find from observation and examination of _____ _____ that she is pregnant, that she is suffering from the following ailment or condition: _____, and that it is medically necessary to perform a therapeutic abortion upon her. Further progress of her pregnancy would gravely endanger or imperil her life. We therefore recommend that a therapeutic abortion be performed.

Date _____

(1) _____

(2) _____

(3) _____

(duly licensed physicians)

NOTE: An abortion is not a crime when performed for therapeutic purposes, that is, when it is necessary to save the life of the patient. The physician should be in a position to establish the therapeutic ground upon which he justified action. In order to best protect himself in this regard, he should obtain and preserve in his file a statement such as the above, signed by at least three reputable physicians (including himself) that they have examined the patient and are of the opinion that an abortion is a medical necessity.

(2) Patient access to health care records. Any patient or other person may, upon submitting a statement of informed consent, (a) inspect the patient's records during regular business hours upon reasonable notice, (b) receive a copy of the patient's records on payment of reasonable costs, (c) receive a copy of the patient's x-ray reports or have the patient's x-ray films referred to a provider of his choice for analysis upon payment of reasonable costs. Wis. Stats. §146.83.

b. Photographs

Physicians may wish to make a visual record of a case for several reasons. In cosmetic surgery it may show the result of the surgery. In other cases it may show the result of a particular method of treatment. It may also be used for unusual cases where documentation would be valuable for teaching purposes. In any of these cases there must be a release of the confidential or privileged relationship to allow the taking of photographs.

c. Observers, motion pictures, television

In cases similar to those where photographs may be desirable, there are cases which should be observed, televised or recorded on film. The release of the confidential or privileged relationship must also be obtained in these cases. Forms 13, 14 and 15 may be used for these situations.

VI. Special situations

There are certain procedures which the physician should approach with caution and be sure to take the necessary steps to document what has happened and, to be sure that he proceeds only with proper authority and consent. These include:

1. **Abortions**
2. **Artificial insemination**
   - ***a. Homologous***
   - ***b. Donor***
3. **Sterilization**
   - ***a. Sterilization as a result of an operation for other purposes***
   - ***b. Therapeutic sterilization***
   - ***c. Nontherapeutic sterilization***

VII. Other consent forms

There are other forms included in the January 1970 "Blue Book" printing that may be of common use to a physician. These forms are believed not to require explanatory text. However, before any of these forms are signed, the physician should review the requirements for a valid consent given earlier in this article. ■

ABORTION

Wisconsin, like several other states, has a law denying subsidies from any public source for non-therapeutic abortions except in cases in which conception results from sexual assault or incest. Laws of this nature have been subject to challenge in the courts in other states. The validity of Wisconsin's law, if challenged, cannot be predicted.

In Wisconsin spousal consent for abortion is not required by law.

Physicians and hospitals are granted immunity from civil liability for refusal to perform abortions. In the case of the physician this immunity is conditioned on the refusal having been based on religious or moral precepts. No hospital, school, or employer may discriminate against a physician in regard to employment, tenure, or staff privileges or status for refusal to perform abortions if this is based on religious or moral precepts.

NEWBORN INFANT EYE DROPS. The permanent administrative rule allowing the use of either silver nitrate, tetracycline, or erythromycin for the prevention of gonococcal ophthalmia in newborn infants became effective October 1, 1980. The new rule also changes the time frame in which the preventive agent must be administered after birth from "immediately" to "as soon as possible, but not later than one hour after birth." Under the rule only one child shall be treated per container. ■

JOINT PRACTICE: PHYSICIANS AND NURSES. Reprints of the following items, which were published in the June 1981 BLUE BOOK issue of the WMJ, are available upon request to: State Medical Society of Wisconsin, Attn: Joint Practice Committee, PO Box 1109, Madison, Wis 53701; or phone (608) 257-6781 in the Madison area or 1-800-362-9080 in Wisconsin:

- **Guidelines for Implementation of Joint Practice of Physicians and Nurses**
- **Statement on Joint Practice**
- **Guidelines for Institutional Joint Practice Privileges** ■

THE WISCONSIN POISON CONTROL PROGRAM NETWORK

It is a health service that provides standardized poison management information and treatment to both medical professionals and the general public through a network of regional and satellite centers.

Each center is staffed by specially trained poison information professionals available to answer telephone inquiries 24 hours a day, seven days a week. Telecopying equipment enables the staff to make immediate contact with national headquarters in Pittsburgh when additional information or research is needed on difficult cases of ingestion.

The centers:

- recommend treatment procedures to physicians and to the public in poison emergencies.
- maintain a record of calls received, treatment advised or given and disposition of the case.
- report certain poison incidents to the Division of Health.

The two regional centers are:

Milwaukee Poison Center
Milwaukee Children's Hospital
1700 W Wisconsin Avenue
Milwaukee, WI 53233
Tel 414/931-4114

Poison Center — Madison Area
University Hospitals
600 Highland Avenue
Madison, WI 53792
Tel 608/262-3702

The three satellite centers are:

Eau Claire Poison Center
Luther Hospital
310 Chestnut Street
Eau Claire, WI 54701
Tel 715/835-1515

Green Bay Poison Center
St Vincent Hospital
835 So Van Buren St
Green Bay, WI 54305
Tel 414/433-8100

LaCrosse Poison Center
St Francis Hospital
709 South 10th Street
LaCrosse, WI 54601
Tel 608/784-3971

In addition, other small poison control centers in many other hospitals may have direct contact with a regional or satellite center to receive assistance as a "member center" of the network.

This information provided by the

WISCONSIN DEPARTMENT OF HEALTH
AND SOCIAL SERVICES
DIVISION OF HEALTH

PO Box 309 Madison, Wis 53701

Wisconsin's Adoption Records Law. . . Chapter 359, Laws of 1981

RECENT LEGISLATION in Wisconsin provides additional opportunities for adoptees and certain other persons seeking identifying information about their birth parents and information about medical and genetic history for themselves or certain other biological family. Chapter 359, Laws of Wisconsin, 1981, became effective May 7, 1982.

Provisions of the new law are described in an *Information Memorandum 82-25,* prepared by the Wisconsin Legislative Council Staff, which follows:

Introduction. Prior to passage of Ch. 359, Laws of 1981, no person was permitted to have access to records and papers pertaining to an adoption proceeding, except upon order of the court for good cause shown. No person in charge of adoption records was permitted to disclose the names of the natural or adoptive parents of a child unless ordered to do so by the court. However, courts in Wisconsin varied considerably in their permissiveness in allowing information to be released.

The purpose of Ch. 359 is to allow persons who have been adopted or whose birth parents' rights have been terminated to gain access to information about their personal history. This information may include medical information which may be needed for identifying a genetically transmitted disease or other medical condition in the adopted person or his or her children or identifying information about the birth parents. The law attempts to balance the adoptee's "right-to-know" with the birth parents' "right-to-privacy" by requiring that *both* birth parents approve the release of identifying information. Under the new law, locating and obtaining approval from the birth parents is the responsibility of the Department of Health and Social Services (DHSS) through a search process spelled out in the law.

In order to establish a readily accessible source of medical information about the adoptee, the law also establishes a new requirement that an agency's report to the court during a termination of parental rights (TPR) proceeding contain medical information about the child and his or her birth parents.

A. Disclosure of information required during termination of parental rights proceedings

1. Procedure where person other than agency files a termination of parental rights petition

Under the Act, if a TPR petition of a *birth parent* is filed by a person other than one of the statutorily prescribed agencies *or* if the court waives the agency report required under s. 48.425, Stats. (i.e., where the parent voluntarily consents to the termination), the court must order any parent whose rights are being terminated to file with the court a *medical record* of the child which shall include the following:

a. The *medical* and *genetic history* of the *birth parents* and any medical and genetic information furnished by the birth parents about the child's grandparents, aunts, uncles, brothers and sisters.

b. A report of any medical examination which either birth parent had within one year before the date of the petition.

c. A report describing the child's prenatal care and medical condition at birth.

d. The medical and genetic history of the child and any other relevant medical and genetic information.

"Birth parent" means either the mother designated on the child's original birth certificate or one of the following:

a. The adjudicated father.

b. If there is no adjudicated father, the husband of the mother at the time of the child's conception, birth or subsequent legitimation [s. 48.432 (1) (a), Stats., as created by Ch. 359, Laws of 1981].

"Child" means a person whose birth parent's rights have been terminated in this state at any time, or who has been adopted in this state with the consent of his or her birth parent or parents *before February 1, 1982* [s. 48.432 (1) (b), Stats., as created by Ch. 359, Laws of 1981]. This date is the effective date of Ch. 81, Laws of 1981, which eliminated the ability of a birth parent to consent to the adoption of his or her child without a TPR prior to the adoption.

If a birth parent does not provide this information, the court must order any health care provider as defined under s. 146.81 (1), Stats.,* known to have provided care to the birth parent or parents, to provide the court with any health care records of the birth parent or parents that are relevant to the child's medical condition or genetic history. A court order which requires the release of alcohol or drug abuse treatment records must comply with applicable federal regulations relating to the release of such records.

2. Procedure where agency files the petition

If a TPR petition is filed by the DHSS, a county department of public welfare or social services or a licensed child welfare agency or if the court directs one of these agencies to submit a report prior to the court's disposition of the TPR petition, the agency is required to file a report with the court which includes certain information on the child and recommendations as to the TPR. The court may *waive* this report requirement if the parents voluntarily consent to the TPR.

*NOTE: The definition of "health care provider" as set forth in Sec. 146.81(1), Wis. Stats. appears in this "Blue Book" issue in the article entitled "Retention and inspection of patients' records."

Under the Act, an agency's report to the court must *also* include a *medical record* of the child which includes the information described in Section A, 1, above.

If the court *waives* the report requirement, the court must order the birth parent or parents to provide the DHSS with the required medical information.

3. Court's actions upon disposition of TPR petition

After receiving evidence related to the disposition of the TPR petition, the court may either dismiss the petition or enter an order terminating the parental rights of one or both parents and either transferring the guardianship and custody of the child to an agency or another person or placing the child in sustaining care under s. 48.428, Stats. [s. 48.427 (1) to (4), Stats., as affected by Ch. 81, Laws of 1981].

Under the Act, if a termination order is entered, the court must also:

a. Inform each birth parent whose rights have been terminated of the provisions of the Act relating to *access to medical information* (discussed in Section B, below) and *access to identifying information about parents* (discussed in Section C, below); and

b. Forward to the DHSS:
(1) The name and date of birth of the child whose birth parents' rights have been terminated.
(2) The names and current addresses of the child's birth parents, guardian and legal custodian.
(3) The medical and genetic information obtained from the birth parent or parents or from any agency in the report to the court or the DHSS described in Section A, 2, above.

4. Information retained in centralized birth record file

The Act requires the DHSS to maintain all of the information obtained from the court under this disclosure provision in a *centralized birth record file.* Any birth parent whose rights to a child have been terminated in this state at any time, or who consented to the adoption of a child *before February 1, 1982* (i.e., before consent adoptions were no longer allowed), is permitted to file with the DHSS any relevant medical or genetic information about the child or the child's birth parents, and the DHSS must maintain the information in the centralized birth record file.

5. Information not admissible to prove paternity

The Act specifies that the medical and genetic information filed with the DHSS or the court is not admissible to prove the paternity of the child.

B. Access to medical information

1. Release of medical information by the DHSS

Under the Act, the DHSS is required to release the medical information described in Section A, 1, in its centralized birth record file to any of the following persons upon request:

a. A child 18 years of age or older.
b. An adoptive parent of an adopted child.
c. The guardian or legal custodian of a child.
d. The offspring of a child if the requester is 18 years of age or older.
e. An agency or social worker assigned to provide services to the child or place the child for adoption.

Before releasing the medical information, the DHSS has to *delete* the name and address of the birth parent and the identity of any provider of health care to the child or to the birth parent.

2. Search for birth parents by DHSS

Under the Act, any person specified in the list in Section B, 1, above, is permitted to request that the DHSS conduct a *search* for the birth parents of any child about whom the DHSS does not maintain information in its centralized birth record file in order to obtain medical and genetic information. The request must be accompanied by a *statement from a physician* certifying either that the child has or may have acquired a *genetically transferable disease* or that the child's *medical condition* requires access to the information.

Upon receipt of a request for a search, the DHSS must undertake a diligent search for the child's parents.

Upon locating a birth parent, the DHSS or an agency conducting the search must notify the birth parent of the request and of the need for medical and genetic information. The DHSS must release to the requester any medical or genetic information provided by a birth parent under this search provision without disclosing the birth parent's identity or location.

If a birth parent is located, but refuses to provide the information requested, the DHSS must notify the requester, without disclosing the birth parent's identity or location. The requester is then allowed to *petition the circuit court* to *order* the birth parent to disclose the information. The court must grant the petition for good cause shown.

3. Notification of child or birth parent of genetically transferable disease

Under the Act, if the DHSS or another agency that maintains records relating to the adoption of a child or the termination of parental rights receives a report from a physician stating that a *birth parent or another child of the birth parent* has acquired or may have a *genetically transferable disease,* the DHSS or agency must notify the *child* of the exis-

tence of the disease, if he or she is 18 years of age or over, or notify the *child's guardian, custodian or adoptive parent* if the child is under age 18. If the DHSS or agency receives a report from a physician that a *child* has acquired or may have a genetically transferable disease, the DHSS or agency must notify the *child's birth parent* of the existence of the disease. Notice under these provisions must be sent to the most recent address on file with the agency or the DHSS.

C. Access to identifying information about parents

1. Affidavit of birth parent and release of identifying information by the DHSS

Under the Act, any birth parent whose rights have been terminated in this state at any time, or who has consented to the adoption of his or her child in this state before February 1, 1982, is permitted to file with the DHSS an *affidavit* authorizing the DHSS to provide the child with his or her original birth certificate and with any other available information about the birth parent's identity and location. An affidavit filed under this provision can be *revoked* at any time by notifying the DHSS in writing.

The Act provides that any person *21 years of age or over* whose birth parents' rights have been terminated in this state or who has been adopted in this state with the consent of his or her birth parent or parents before February 1, 1982, may request the DHSS to provide the person with the following:

a. The person's original birth certificate.
b. Any available information regarding the identity and location of his or her birth parents.

Before acting on the request, the DHSS must require the requester to provide adequate identification.

If *both* birth parents have filed unrevoked affidavits or if one of the birth parents was unknown at the time of the TPR proceeding or adoption and the known birth parent has filed an unrevoked affidavit, the DHSS must disclose the requested information.

2. Search for birth parent if no affidavit on file

Under the Act, if the DHSS does not have on file an affidavit from each birth parent, it must, *within three months* after the date of the original request, undertake a diligent *search* for each birth parent who has not filed an affidavit. The search must be completed *within six months* after the date of the request. If any information about a birth parent has been provided by the DHSS from unrevoked affidavits on file by both birth parents, the DHSS is not required to conduct a search.

Upon locating a birth parent, the DHSS or an agency conducting the search is required to make at least *one verbal contact* with the birth parent and notify him or her of the nature of the information requested, the date of the request, and the fact that the birth parent has the right to file with the DHSS the affidavit described above. Within three working days after contacting a birth parent, the DHSS must send the birth parent a written copy of this information (i.e., the nature of the information requested, the date of the request and the right to file an affidavit) and a blank copy of the affidavit.

If a known birth parent cannot be located after a search and the other birth parent has filed an unrevoked affidavit, the DHSS may disclose the requested information. The DHSS or agency conducting the search may not contact that birth parent again on behalf of the same requester until at least *12 months* after the date of the previous contact. Further contacts with a birth parent on behalf of the same requester can be made only if *five years* have elapsed since the date of the last contact.

3. Where birth parent known to be dead

Under the Act, if a birth parent is known to be dead and has not filed with the DHSS an unrevoked affidavit, the DHSS must so inform the requester. The DHSS is not allowed to provide the requester with his or her original birth certificate or with the identity of that parent, but shall provide the requester with any information about that parent on file with the DHSS and any available information about the identity and location of the other birth parent if the other birth parent has filed an unrevoked affidavit and the deceased parent has been dead for at least one year.

4. Circuit Court petition for disclosure of information

Under the Act, the requester is allowed to petition the *circuit court* to order the DHSS to disclose any identifying information about a birth parent. The court must grant the petition for good cause shown.

D. Other provisions

1. Cooperation of other agencies in conducting searches

Upon request by the DHSS, a county social services or welfare department or licensed child welfare agency must cooperate in a search for a birth parent and must make its records available to the DHSS. The DHSS *cannot require* an agency to conduct the search but can designate an agency to do so with the agency's consent. Employers of the DHSS and any agency conducting a search are not permitted to inform any person other than the birth parents of the purpose of the search.

2. Fees for searches

The DHSS or the agency designated by the DHSS is required to charge the requester a *reasonable fee* for the cost of the search. When the DHSS or agency determines that the fee will *exceed $100* for either

birth parent, it must notify the requester. No fee in excess of $100 per birth parent may be charged unless the requester gives consent to proceed with the search.

3. Immunity from liability

Any person, including the state or any political subdivision of the state, who participates in *good faith* in any requirement of the Act is *immune* from any civil or criminal liability that results from his or her actions. In any civil or criminal proceeding, the good faith of any person participating in the requirements of the Act is presumed.

4. DHSS rule-making authority

The Act requires the DHSS to adopt administrative rules to implement the provisions in Sections B and C of this memorandum.

5. Initial applicability

The following provisions in the Act apply only in TPR proceedings commenced on or after May 7, 1982, the effective date of the Act:

a. The requirement for birth parents in TPR proceedings to file medical and genetic information with the court or with DHSS (Section A, 1 and 2, above);

b. The requirement for agencies to include a medical record of the child in a report to the court for a TPR proceeding; and

c. The requirement for the court which has entered a TPR order to forward to the DHSS the medical and genetic information and other information on the child and the child's birth parents (Section A, 3, above). ■

CHECKLIST FOR COST CONTAINMENT

Adopted by the State Medical Society of Wisconsin, March 28, 1981

I. Encourage physicians to:

A. Be cost conscious
B. Learn consultant fees
C. Include recent laboratory and x-ray results with referral letters
D. Avoid unnecessary referrals
E. Utilize "one day" care units when possible
F. Consider "morning of surgery" admissions
G. Be selective in use of expensive critical care units
H. Shorten postoperative hospital stays
I. Encourage early evaluation for transfer to extended care facility
J. Critically examine prescribing habits
K. Order only necessary laboratory tests
L. Periodically review hospital bills to learn costs of laboratory, radiology and ancillary services
M. Seek alternatives to hospitalization
N. Discourage "routine" annual physical examinations
O. Discourage "executive physicals"
P. Combine camp, school and athletic examinations

II. Encourage hospitals to:

A. Form cost containment committees
B. Instruct patients on appropriate use of the emergency room
C. Avoid excessive use of laboratory and radiology services in the emergency room
D. Be fully functional on weekends and holidays
E. Post up-to-date patient bills
F. Share purchasing services

III. Encourage patients to:

A. Be aware of health care costs
B. Practice good health habits
C. Evaluate the alleged merits of health foods, vitamins, minerals, etc.
D. "Self treat" minor illnesses and injuries
E. Discuss prescription costs with family pharmacist
F. Use over-the-counter and generic medication when possible
G. Learn about cost savings available in health insurance plans with deductibles and co-insurance ■

PESTICIDE POISONING TREATMENT MANUAL AVAILABLE. The SMS Committee on Environmental and Occupational Health informs physicians that a pesticide medical treatment manual is available to physicians at no charge from the US Environmental Protection Agency. The 75-page manual, "Recognition and Management of Pesticide Poisonings," devotes a separate chapter to each major chemical classification of pesticides detailing: 1) names of commonly used pesticides belonging to the group; 2) toxicology; 3) frequent signs and symptoms of overexposure, and 4) recommended treatment. To obtain a free copy, physicians must make their request on their professional stationery to: Chief, Pesticide Branch, US Environmental Protection Agency, 230 South Dearborn Street, Chicago, Illinois 60604. ■

The adoption process in Wisconsin

INFORMATION MEMORANDUM 81-6, Wisconsin Legislative Council Staff, December 8, 1981
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THIS INFORMATION MEMORANDUM describes the process by which a potential adoptive parent adopts a child in Wisconsin. A child from Wisconsin or from another state or country may be adopted in this state with or without the services of an adoption agency. Included in this Information Memorandum is:

- *Agency adoptions* (agencies involved, procedures used in agency adoptions)
- *Independent adoptions* (introduction, adoption by relatives, placement of children with nonrelatives for adoption)
- *Interstate adoptions*
- *Foreign adoptions*
- *Appendix 1—Adoption process under Ch. 81, Laws of 1981, for birth parent placing child with nonrelative*

If a statutory provision has been affected by Ch. 81, Laws of 1981, that fact will be noted in this Information Memorandum. That law will take effect on February 1, 1982.

AGENCY ADOPTIONS

Agencies involved

The following agencies are allowed under state law to accept guardianship of a child being placed for adoption and, without a court order, to place the child for adoption:

1. Milwaukee County Department of Social Services, under s. 48.57 (1) (e), Stats.
2. Wisconsin Department of Health and Social Services (DHSS) regional offices, under s. 48.48 (8) and (9), Stats. The DHSS provides adoption services in all counties except Milwaukee County.
3. A child welfare agency licensed under s. 48.60 (1), Stats., which is given the authority under its license to accept guardianship as provided in s. 48.61 (5), Stats.

In this Information Memorandum, the word *agency* includes all of the above agencies, unless otherwise indicated. Agencies in the third category listed above are called child welfare agencies in the statutes but are commonly referred to as private or voluntary adoption agencies. There are currently nine child welfare agencies licensed in Wisconsin to accept guardianship of children. In addition, there are several agencies licensed in this state under s. 48.60 (1), Stats., which are not licensed to accept guardianship of children but do provide assistance to potential adoptive parents in arranging for the adoption of a foreign child.

Table 1 shows the number of adoptive placements made by licensed guardianship agencies in Wisconsin in 1980.

Procedures used in agency adoptions

According to DHSS, the procedure used in matching a child with potential adoptive parents can vary depending on whether the adoption is processed by the Milwaukee County Department of Social Services, the DHSS or a private adoption agency.

In September 1980, the DHSS promulgated administrative rules setting forth the procedure to be used for adoption services provided by *DHSS* [ch. HSS 51, Wis. Adm. Code]. The rules contain detailed requirements for the court-ordered home study, described below, and detailed eligibility criteria for the potential adoptive parents.

There are no rules governing the procedure to be followed by *licensed child welfare agencies* in providing adoption services. Each agency is given the discretion to develop its own procedure, subject to limitations of state statutes. The procedures used in a typical agency adoption may vary with each agency but would normally involve the following steps:

1. ***Inquiry application.*** Persons interested in obtaining information about becoming adoptive parents file an application with the agency.

2. ***Orientation meeting.*** The purpose of this meeting is to allow the agency providing adoption services to obtain basic information about the potential adoptive parents. The potential adoptive parents also learn about the adoption process and the responsibilities and issues involved in adopting a child.

3. ***Formal application by the potential adoptive parents.*** If the persons decide they wish to become adoptive parents, a formal application is filed with the adoption agency.

4. ***Home study by the agency.*** The home study consists of interviews with the potential adoptive parents and at least one visit to their home by the agency representative to evaluate whether it is appro-

TABLE 1—*Adoptive placements by agencies licensed in Wisconsin, 1980*

Agency	*Total children placed by agency in 1980*	*Children with special needs placed in 1980*
DHSS Regional Offices	339	208
Milwaukee County	67	42
Private Adoption Agencies	444	78
Total Agency Placements	850	328

Source: Wisconsin Adoption Resource Exchange, Annual Report of 1980 Placements, March 19, 1981.

priate for the placement of the child. The home study may also include inquiries into the financial, social and medical backgrounds of the potential adoptive parents.

5. *Approval of the potential adoptive parents for possible placement.* Approval is given by the agency to which the application was submitted if the agency determines that the potential adoptive parents are qualified to be adoptive parents.

6. *Finding a child for placement.* This step involves matching a child with the potential adoptive parents. Among the factors considered in matching a child are the preference of the potential adoptive parents and whether those persons can satisfy the needs of the child. The potential adoptive parents must also be of the same religious faith as the natural parents of the child, when practicable [s. 48.82 (3), Stats.]. According to DHSS, it can take several years following approval for a placement before a child is actually placed if the potential adoptive parents wish to adopt a healthy infant or a child without "special needs." Children with "special needs" are defined as those who are:

a. Minorities;
b. Physically handicapped; or
c. Placed as part of a sibling group.

7. *Familiarizing the potential adoptive parents with the child.* Once a suitable child for the potential adoptive parents is found, meetings are held between the agency and the potential adoptive parents to explain the child's background. One of these meetings includes face-to-face contact between the potential adoptive parents and the child.

8. *Licensure of the home of the potential adoptive parents as a foster home.* Prior to placing a child in the home of the potential adoptive parents, the home must be licensed as a foster home under s. 48.62 (1), Stats. That subsection provides that no person may receive, with or without the transfer of legal custody, four or fewer children to provide care and maintenance unless he or she obtains a license to operate a foster home. Foster homes may be licensed by DHSS, a county social services department or a licensed child welfare agency. Licensure of the foster home is not required if the potential adoptive parent is a relative of the child, as enumerated in s. 48.02 (15) or 49.19 (1) (a), Stats., or if that person is a guardian of the child.

9. *Signing a placement agreement between the agency and the potential adoptive parents.* Section 48.64 (1), Stats., states that the placement agreement between the agency and the potential adoptive parents shall provide that the agency shall have access at all times to the child and the home and that the child will be released to the agency whenever, in the opinion of the agency or DHSS, "the best interests of the child require it."

10. *Placement of the child in the home of potential adoptive parents.* Section 48.90 (2), Stats., as amended by Ch. 81, Laws of 1981, states that no petition for adoption may be filed unless the child has been in the home of the petitioner for six months or more. During the six-month period, the home would be licensed as a foster home. The six-month requirement does not apply if one of the petitioners is a relative of the child by blood, if the petitioner is the child's stepparent, if the petition is accompanied by written approval of the guardian or if the petitioner is the proposed adoptive parent with whom the child has been placed in a foreign adoption.

11. *Filing a petition for adoption in circuit court.* The petition for adoption is filed under s. 48.83, Stats., with the circuit court of the county in which the child is located. Chapter 81, Laws of 1981, amended this section to allow a court to transfer the case to a court in the county in which the proposed adoptive parents reside.

12. *Preadoption investigation.* Section 48.88 (2) (a), Stats., as amended by Ch. 81, Laws of 1981, requires the court, upon the filing of an adoption petition, to order the agency having guardianship of the child to investigate the suitability of the proposed adoption. The agency is required to report to the court at least 10 days before the hearing on the adoption petition. According to DHSS, the home study described in number 4 above might, in some cases, be substituted for the preadoption investigation. This is permitted under s. 48.88 (2) (b), Stats.

13. *Written recommendations by the agency filed with the court.* Section 48.841, Stats., provides that no adoption of a minor may be ordered without the written recommendation, favorable or unfavorable, of a guardian of the minor if there is a guardian. The written recommendation must be filed at least 10 days prior to the adoption hearing [s. 48.85 (1), Stats.]. However, if the guardian refuses or neglects to file a recommendation in time, the court may proceed as though the guardian has filed a favorable recommendation.

14. *Adoption hearing.* The purpose of this hearing is to finalize the adoption. After the hearing and the study of the preadoption investigation report, the court makes an order granting the adoption if it determines that the adoption is in the best interests of the child. If the adoption is not granted, the court decides on an alternative placement for the child.

15. *Issuance of a new birth certificate.* After entry of the order granting the adoption, the clerk of courts mails a copy of the order to the Bureau of Vital Statistics within DHSS [s. 48.94, Stats.]. The Bureau of Vital Statistics then issues a new birth

certificate. However, if the adoptive parents request that the birth certificate of the adopted person not be changed, then no new birth certificate is issued.

INDEPENDENT ADOPTIONS

Introduction

An independent adoption is one in which the adoption is arranged and completed without the services of an adoption agency. Prior to enactment of Ch. 81, Laws of 1981, there were few restrictions placed on the independent adoptive placement of children. These requirements included licensure of the proposed adoptive home as a foster home (unless exempted by law from this requirement), investigation of the proposed adoptive home by an agency, filing of the adoption petition, obtaining the parent's or parents' consent to the adoption and the final hearing and judgment on the adoption petition. Chapter 81, Laws of 1981, which will take effect on February 1, 1982, sets out new requirements governing the placement of a child for adoption, requires the filing of a petition to terminate parental rights and makes several changes in the hearing process.

The number of independent adoptions which take place in Wisconsin each year is not definitely known. A fiscal estimate to 1981 Assembly Bill 369 prepared by DHSS stated that an estimated 100 independent adoptions take place in Wisconsin each year. However, another fiscal estimate to the Bill prepared by the Office of the State Public Defender estimated the number at 600 to 900 independent adoptions each year.

Adoption by relatives

Chapter 81 clarified the laws governing the independent placement of children with relatives for adoption. "Relative" is defined in s. 48.02 (15), Stats., to include a parent, grandparent, brother, sister, first cousin, nephew, niece, uncle or aunt. The list of relatives in s. 49.19 (1) (a), Stats., includes those persons and stepfather, stepmother, stepbrother and stepsister.

Chapter 81 changes current law to allow a parent having physical custody of his or her child to place the child for adoption in the home of a relative without a court order [s. 48.835 (2)]. Chapter 81 also allows a court to transfer guardianship and custody of a child to a relative after parental rights to the child have been terminated if the relative has filed a petition to adopt the child [s. 48.427 (3) (a) 5, as created by Ch. 81, Laws of 1981]. The current provision in which relatives are not required to obtain a foster home license is retained [s. 48.62 (2)].

Another change made by Ch. 81 requires a termination of both parents' rights before either a relative or nonrelative may adopt the child [s. 48.835 (3) (a), as created by Ch. 81, Laws of 1981]. Prior to enactment of Ch. 81, a parent could consent to the adoption without a termination of parental rights prior to the final adoption order. If the child is residing with one natural parent and is being adopted by a stepparent, the parental rights of the parent who does not have custody of the child must be terminated [s. 48.835 (3) (b), as created by Ch. 81, Laws of 1981].

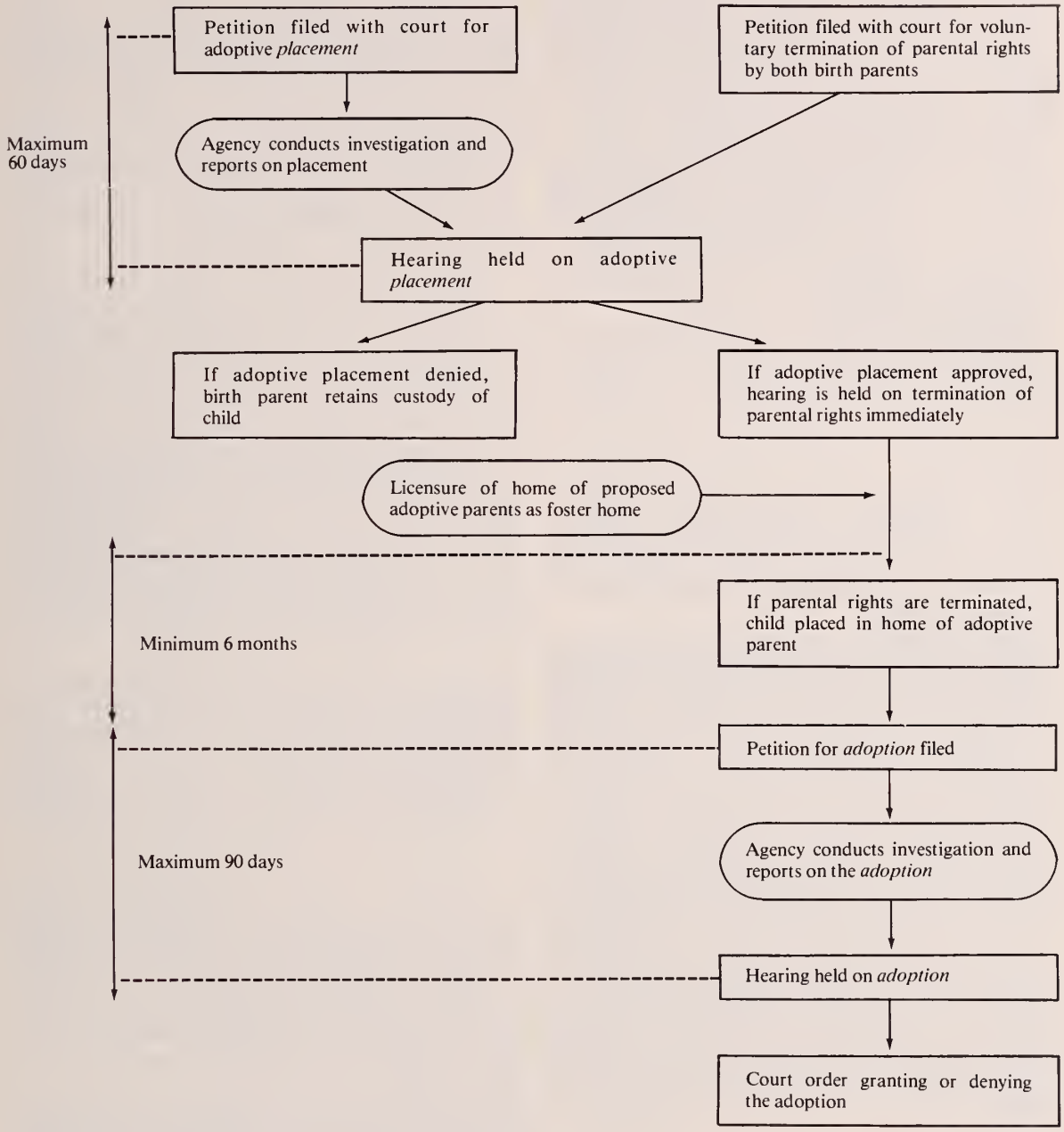
Placement of children with nonrelatives for adoption

Chapter 81 revises certain laws and creates new requirements for the placement of children with nonrelatives for adoption. Under current law, a parent may place the child for adoption in any home with the approval of a court, if the home is licensed as a foster home. Chapter 81 retains the provisions for court approval and foster home licensure and adds additional requirements which must be met before the child can be placed with a nonrelative. The new law requires that the parent having custody of the child and the proposed adoptive parent or parents of the child file a joint petition for placement of the child in the proposed adoptive parents' home [s. 48.837 (1), as created by Ch. 81, Laws of 1981]. The new law details the information which must be included in the petition [s. 48.837 (2), as created by Ch. 81, Laws of 1981]. The petitioners' must also file at the same time a petition to voluntarily terminate the existing rights of the parents [s. 48.837 (3), as created by Ch. 81, Laws of 1981].

After the two petitions are filed, the adoption process proceeds in a manner similar to that of an agency adoption. Upon the filing of the two petitions, the court is required to schedule a hearing on the petitions within 60 days but the hearings may not be held before the birth of the child [s. 48.837 (4) (a), as created by Ch. 81, Laws of 1981]. The court then orders DHSS or the Milwaukee County Department of Social Services to investigate the proposed adoptive placement [s. 48.837 (4) (c), as created by Ch. 81, Laws of 1981]. If a licensed adoption agency has already investigated the placement, the court may accept the agency report in place of the court-ordered report. The proposed adoptive parents must pay the cost of this investigation according to a sliding fee schedule established by DHSS [s. 48.837 (7), as created by Ch. 81, Laws of 1981]. The court may also order at the request of the petitioning birth parent, to have the child placed in a licensed foster home until the hearings are held [s. 48.837 (4) (d), as created by Ch. 81, Laws of 1981]. The proposed adoptive parents are also required to pay for these foster care costs, if any [s. 48.437 (7), as created by Ch. 81, Laws of 1981].

Chapter 81 requires that the hearings on the adoptive placement and the termination of parental rights be held in immediate succession, with the adoptive placement hearing held first [s. 48.837 (6) (a), as created by Ch. 81, Laws of 1981]. After the court decides on the child's adoptive placement, it must proceed immediately to the hearing on the termination of parental rights. If parental rights are

APPENDIX 1
Adoption process under Ch. 81, Laws of 1981, for birth parent placing child with nonrelative



terminated, the court then orders the child placed with the proposed adoptive parents and appoints an agency as guardian of the child [s. 48.837 (6) (b), as created by Ch. 81, Laws of 1981].

The adoption process then continues with the same steps as in an agency adoption: the filing of the adoption petition in court after the child has been in the home of the adoptive parents for at least six months; a court-ordered preadoption investigation by an agency; a written recommendation by the agency serving as guardian to the child; and the final adoption hearing and the court's decision on whether to finalize the adoption.

The major steps in the adoption of a child by a nonrelative is illustrated in *Appendix 1.*

Chapter 81 also creates a penalty for the placement of a child for adoption for anything of value. A person found guilty of violating s. 946.716, as created by Ch. 81, Laws of 1981, could be sentenced to a fine not to exceed $10,000 or imprisonment not to exceed two years, or both. This is the maximum penalty for a Class E felony. This penalty does not apply to agency adoptions or interstate or foreign adoptions.

INTERSTATE ADOPTIONS

Interstate adoptions are those in which a Wisconsin child is being adopted by persons in another state or a child from another state is being adopted by persons in Wisconsin. Most interstate adoptions are governed by s. 48.988, Stats., the Interstate Compact on the Placement of Children. All other interstate adoptions are governed by s. 48.98, entitled the Interstate Placement of Children.

The DHSS estimates that approximately 60 placements involving approximately 100 children from other states were made in Wisconsin in 1980. The difference in the number of placements and the number of children is due to the fact that placement of a sibling group containing two or more children is counted as one placement.

The Interstate Compact on the Placement of Children requires that the DHSS approve all interstate placements governed by the Compact. The Compact also requires that all applicable laws of the receiving state be complied with and that the sending state retain jurisdiction over the child in determining all matters relating to custody, supervision, care, treatment and disposition of the child until the child is adopted. The Compact does *not* apply to the interstate placement of a child with a *relative* or to interstate adoptions with states which are not members of the Compact.

Interstate adoptions which are not covered by the Interstate Compact also must receive the approval of DHSS before the child can be placed [s. 48.89 (1) (c)]. Any person bringing a child into this state for the purpose of placing the child in a foster home for adoption must file with DHSS a $1,000 bond in favor of this state [s. 48.98 (2) (a), as amended by Ch. 81, Laws of 1981]. The bond is to ensure that the child will not become dependent on public funds for his or her primary support before the child reaches age 18 or is adopted. If this requirement is violated, the person who filed the bond and the surety company which issued the bond shall be billed for the cost of care and maintenance of the child until the child is adopted or becomes age 18 and for the costs incurred by the DHSS in enforcing the bond. The bond requirement may be waived by DHSS [s. 48.98 (2), as amended by Ch. 81, Laws of 1981].

FOREIGN ADOPTIONS

Chapter 81, Laws of 1981, makes substantial changes in state laws governing foreign adoptions. Currently, s. 48.97, Stats., is the only statutory provision which addresses foreign adoptions. However, many foreign adoptions come under the jurisdiction of the Interstate Compact on the Placement of Children due to the fact that most of the agencies which place foreign children in Wisconsin are based in and licensed in other states.

According to DHSS, 115 foreign children were adopted in Wisconsin in 1980. There is no estimate available of the number of children adopted *in* foreign countries by Wisconsin residents and brought to Wisconsin.

The current procedures for adopting a foreign child in Wisconsin include several steps. First, the proposed adoptive parents must arrange independently or through a licensed adoption agency for the placement of a foreign child in Wisconsin. In most cases, DHSS must approve the placement in accordance with the Interstate Compact on the Placement of Children. In all other cases, the recommendation of the DHSS for the adoption of a nonresident minor is required by s. 48.89 (1) (c), Stats.

Chapter 81, Laws of 1981, requires any resident of Wisconsin who has been appointed by a foreign court as guardian of a foreign child for the purpose of adopting that child to file a $1,000 bond with DHSS [s. 48.839 (1), as created by Ch. 81, Laws of 1981]. The condition of the bond is that the child will not become dependent on public funds for his or her support before he or she is adopted or reaches age 18. If the condition of the bond is violated, the guardian and the surety company issuing the bond shall be liable for the cost of care and maintenance for the child until the child is adopted or becomes age 18. The DHSS may waive this bond requirement.

Chapter 81 also allows an individual to accept guardianship of a child if the guardianship was transferred by a court of a foreign jurisdiction [s. 48.427 (3) (a) 6, as created by Ch. 81, Laws of 1981]. Individuals are currently not allowed to accept guardianship of a child for the purpose of adoption in Wisconsin.

Any resident of the state who has been appointed as guardian of a child by a foreign court must present a copy of the court order or judgment or other instrument legally freeing the child for adoption to DHSS. If DHSS determines that the judgment or order has the effect of freeing the child for adoption and all other requirements have been met, DHSS shall certify to the U.S. Immigration and Naturalization Service (which issues a visa to the foreign child) that all preadoptive requirements of this state have been met [s. 48.839 (2), as created by Ch. 81, Laws of 1981].

Within 60 days after the arrival of a foreign child into this state for the purpose of adoption, the child's guardian must file a petition to adopt the child, a petition to terminate parental rights to the child, or both. If only a petition to terminate parental rights to the child is filed, the guardian must file a petition for adoption within 60 days after the order terminating parental rights. The guardian is also required to file with the court the documents which certify that the child was legally freed for adoption in the country of origin [s. 48.839 (3), as created by Ch. 81, Laws of 1981].

After the petition for adoption is filed, the court shall determine whether the instrument filed which released the child for adoption, if it is not a court order or judgment, has the effect under the laws of the foreign jurisdiction of freeing the child for adoption [s. 48.439 (3) (d), as created by Ch. 81, Laws of 1981].

WISCONSIN ADOPTION AGENCIES

Licensed Voluntary Agencies

Catholic Social Services—Diocese of Green Bay, 131 South Madison St, PO Box 38, Green Bay 54305

Catholic Charities, Inc,—Diocese of LaCrosse, 128 South 6th St, PO Box 266, LaCrosse 54601

Catholic Social Services—Diocese of Madison, 25 South Hancock St, Madison 53703

Catholic Social Services of the Archdiocese of Milwaukee, Inc, 207 East Michigan St, Milwaukee 53202

Children's Service Society of Wisconsin, 610 North Jackson St, Milwaukee 53202

Lutheran Children's Friend Society, 8138 Harwood Ave, PO Box 13367, Wauwatosa 53213

Lutheran Social Services of Wisconsin and Upper Michigan, 3200 West Highland Blvd, Milwaukee 54308

Seven Sorrows of Our Sorrowful Mother Infants' Home, Rt #1, Box 905, Necedah 54646

Wisconsin Lutheran Child and Family Service, 6800 North 76th St, Milwaukee 53233

Public Agencies

Division of Community Services (Regional Offices) (See page 124 for list of Regional Offices.)

Milwaukee County Department of Social Services, Child Welfare Division, 1220 West Vliet St, Milwaukee 53205

Maternity Homes

Lutheran Maternity Home, 1910 South Avenue, LaCrosse 54601

Rosalie Manor, 19305 West North Ave, Brookfield 53005

* * *

Agencies licensed to make adoptive home studies and to contract with other agencies to make placements but not licensed to accept guardianship.

The Human Element, Inc, 2701 North 56th St, Milwaukee 53210

Soul, Ltd, 6185 Rosewood Dr, Appleton 54911

If the guardian does not file either the petition for termination of parental rights or the petition for adoption, or if the petition for adoption is withdrawn or denied, the court is required to transfer guardianship of the child to an agency and order the new guardian to file a petition for termination of parental rights. The court shall transfer legal custody of the child to a county department of social services or a licensed child welfare agency and may grant physical custody of the child to an individual with whom the child has been living [s. 48.839 (4) as created by Ch. 81, Laws of 1981].

Chapter 81 requires that any child welfare agency licensed under s. 48.60 that arranges for the placement of foreign children for adoption provide services to the child and to the proposed adoptive parents until the child's adoption is final [s. 48.839 (5), as created by Ch. 81, Laws of 1981]. ■

Jail health care in Wisconsin

SINCE 1976 THE State Medical Society of Wisconsin has been working with interested sheriff's departments on a *voluntary* basis to develop health care systems using the AMA's Standards for Health Services in Jails, in Juvenile Correctional Facilities, and in Prisons. Although the AMA does the accrediting of jails, the State Medical Society provides ongoing consultation which includes technical assistance emphasizing the use of existing community resources such as the county nursing service and mental health and alcoholism counselors from the Unified Services Board.

Interested physicians or institutions desiring more information on what constitutes adequate care for incarcerated persons may contact the State Medical Society of Wisconsin, Attention Bill Wendle, PO Box 1109, Madison, Wis 53701; or phone (608) 257-6781 in the Madison area or 1-800-362-9080 (toll-free) in Wisconsin. ■

Jail Health Care Technical Assistance Committee: Warren H Williamson, MD, Racine, *chairman;* Irwin J Bruhn, MD, Walworth; Paul R Glunz, MD, Beaver Dam; Pauline M Jackson, MD, LaCrosse; Eugene R Jonas, MD, Ellsworth; Clarence W Jordahl Jr, MD, Waukesha; and representatives from the following organizations: Council on Criminal Justice; State Bureaus of Alcoholism and Other Drug Abuse, Community Corrections, Institutional Health, and Mental Health, UW-Extension, Department of Governmental Affairs; Wisconsin League of Women Voters; Wisconsin Public Health Association; and Wisconsin Sheriff's and Deputy Sheriff's Association.

New law on abuse, diversion of prescription drugs

ON APRIL 21, 1982 the Governor signed into law several important changes dealing with abuse and diversion of prescription drugs. The changes that relate to physicians are provided for your information along with some observations on trends in the prescription drug diversion problem.

- Pentazocine (Talwin 50 and Talwin injectable) is moved from Schedule III to Schedule II. This means that as of April 21, 1982 prescriptions for Talwin must be in writing, are not refillable, and may be for a maximum 34 days' supply or 120 dosage units, whichever is less. Talwin Compound remains in Schedule III. These additional restrictions became necessary because of increasing practitioner diversion. Talwin and pyribenzamine (T's and Blues) are injected together as a heroin substitute.
- The present informal diversion prevention and control of the Controlled Substances Board Program is now a statutory requirement. The Board will work closely with enforcement and licensing authorities, including the Medical and Pharmacy Examining Boards, to detect and respond to diversion of controlled substances by physicians and pharmacists.

Passed by the Legislature unanimously, both of these changes signify Wisconsin's commitment to solving problems of controlled substances diversion. Moving Talwin to Schedule II is one part of the four-part strategy to stop the epidemic of abuse of "T's and Blues" in Wisconsin.

The other parts are law enforcement action against organized crime participants in Talwin diversion; removal of Talwin from the Medical Assistance Program reimbursement; and discipline of physicians and pharmacists who aid diversion of Talwin. Representatives of the Controlled Substances Board recently met with the Medical and Pharmacy Examining Boards and the Secretary of the Department of Regulation and Licensing to appeal for swift action against licensees who divert controlled substances to illicit use.

Because of the anticipated reluctance in availability of Talwin due to this more restrictive scheduling, and because of other emerging trends in the ever-changing collage of the drug scene, physicians and pharmacists should always be on the alert for increasing demands by drug abusers for a variety of controlled substances. Already, increased diversion of Dilaudid has been documented in Wisconsin. Other trends occurring nationwide, which will impact on Wisconsin, include abuse of codeine preparations and the use of another heroin substitute called "loads" which is an injected combination of Doriden (glutethimide) and codeine compounds.

The diversion of prescription controlled substances to illicit uses can and does result in increased morbidity, criminal activity, and admissions to drug abuse treatment programs in every community. Physicians should be cautious with patients with a history of drug abuse and should be suspicious of patients unfamiliar to them who request specific drugs that are controlled substances.

Physicians having questions or concerns should direct them to Darold A Treffert, MD, Chairman, Controlled Substances Board, 459 East First Street, Fond du Lac, Wis 54935, or phone (414) 929-3500; or the Board staff: Mr David Joranson, Controlled Substances Board, Bureau of Alcohol and Other Drug Abuse, 1 West Wilson St, POBox 7851, Madison, Wis 53707, or phone (608)266-7586. ■

Can You Practice Without a License?

THE PRACTICE OF medicine and surgery within this state requires a license. Even physicians just finishing their military service, or moving to Wisconsin from another state, *must* be licensed in this state before they enter active practice. Failure to complete licensure before beginning practice may subject the physician to disciplinary action as well as criminal penalties.

Temporary licenses may be granted under special circumstances by the State Medical Examining Board. Emergency treatment and consultation with licensed Wisconsin practitioners may be undertaken by physicians not licensed in this state. But, the general rule is that a physician must have a Wisconsin license to practive in this state. ■

PHYSICIANS *NOT* EXEMPT FROM JURY DUTY. Physicians are no longer automatically exempt from serving as a juror. However, there are some qualifying circumstances under which a physician might be excused in the discretion of a judge for hardship or extreme inconvenience. Physicians interested in further details may contact the SMS Physicians Alliance Division.

The AMA House of Delegates approved the *Guidelines for Prescribers of Controlled Substances* at its Interim Meeting in December 1979 after the Board of Trustees recommended endorsement. The Drug Enforcement Agency (DEA) and its Practitioners' Working Committee, of which the AMA is a member, developed these suggested principles for good prescribing practices to "provide a common-sense approach to encourage voluntary compliance by the prescribing professions." Other members of the Committee are the American Dental Association, American Nurses Association, American Osteopathic Association, American Pediatry Association, American Veterinary Medical Association, and the National Institute on Drug Abuse. The AMA Board of Trustees has described the guidelines as "intended to remind practitioners of the potential of controlled substances for drug abuse and dependence, without being restrictive in any sense of the physician's prerogative to prescribe as he sees fit in the best interests of his patients."

Guidelines for prescribers of controlled substances

A Joint Statement of the Drug Enforcement Administration and the DEA/Practitioners Working Committee

THE FOLLOWING embodies the collective thinking of members of the DEA/Practitioners Working Committee. First formed in 1974, this Committee has provided a forum for DEA officials and association executives and practitioners to meet voluntarily to discuss items, issues, and subjects of mutual interest, areas of practical concern, and generally maintain an open and responsive attitude among the various members. Having no intrinsic authority, and seeking none, the DEA/Practitioners Working Committee believes it has played a significant role in promoting the generally harmonious relationships which exist between its national organizations and their respective members. It is against this background of shared experience and knowledge that participants in the work of this Committee offer these "Guidelines for Prescribers of Controlled Substances" to members of the professions throughout the country.

Purpose. The purpose of this joint statement and the presentation of guidelines is to provide and establish acceptable professional responses to the demands of the Controlled Substances Act. The guidelines provide a common sense approach to encourage voluntary compliance by the prescribing professions.

General Statement. The principles expressed in these guidelines constitute neither a pronouncement of law nor a code of ethics, and are not intended to in any way supercede or be in conflict with statutes or ethical concepts governing the conduct of the various practitioners in their respective practices or in their respective professional organizations. Accountability is the responsibility of each discipline.

Application of State and Federal Law. Separate laws relating to the distribution of controlled substances have been enacted in most states. In many cases state law is much more stringent than Federal law and will not allow certain practices which may be authorized under Federal law. The guidelines are an example of good practices which should be encouraged under both Federal and state laws and regulations. Close cooperation and understanding between law enforcement and medicine will ensure that legitimate drugs remain in legitimate channels.

Communication. Recognizing that members of each profession have special competencies and knowledge concerning drugs and related therapeutic agents, a free exchange of information on these matters is encouraged among the professions at all levels.

General Guidelines

- Controlled substances have legitimate clinical usefulness and the prescriber should not hesitate to consider prescribing them when they are indicated for the comfort and well being of patients.
- Prescribing controlled substances for legitimate medical uses requires special caution because of their potential for abuse and dependence.
- Exercise good judgment in administering and prescribing controlled substances so that diversion to illicit use is avoided and the development of drug dependence is minimized or prevented.
- Guard against contributing to drug abuse through injudicious prescription writing practices, or by acquiescence to unwarranted demands of some patients.
- Each prescriber is asked to examine his/her individual prescribing practices to ensure that all prescription orders for controlled substances are written with caution.
- Make specific effort to ensure that multiple prescription orders are not being obtained by the patient from different prescribers.

Guidelines—Prescription Orders

The prescriber is granted through legal authority the right to prescribe medications that are necessary for the proper treatment of his/her patients. Pre-

scribing is governed by laws and regulations which set minimum standards and requirements. These guidelines, tempered with good moral and ethical considerations, give guidance to going beyond the minimum requirements.

- The prescription order must be signed by the prescriber when it is written. The prescriber's name, address, and DEA registration number and full name and address of the patient must be given when prescribing controlled substances.
- The written prescription order should be precise and distinctly legible to enhance exact and effective communications between prescriber and dispenser.
- The prescription order should indicate whether or not it may be renewed and, if so, the number of times or the duration such renewal is authorized.
- Prescription orders for drugs in Schedules III, IV, and V may be issued either orally or in writing and may be renewed if so authorized on the prescription order. However, the prescription order may only be renewed up to five times within six months after the date of issue.
- A written prescription order is required for drugs in Schedule II. The renewing of Schedule II prescription orders is prohibited. Only in an emergency situation may oral orders for Schedule II drugs be accepted by a dispenser.
- Controlled substances which are prescribed without indication for renewal cannot be renewed without authorization by the prescriber.
- Prescribe no greater quantity of a controlled substance than is needed until the next check-up.
- Try to make prescription orders alteration-proof.
- When prescribing a controlled substance, write out the actual amount in addition to giving an Arabic number or Roman numeral in order to discourage alterations in written prescription orders.
- Prescribers are encouraged to consider placing a number of check-off boxes on their prescription blanks which show amounts within which the prescribed amount falls, *i.e.,* 1-25, 26-50, 51-100, over 100.
- Use separate prescription blank for each controlled substance prescribed.
- The use of prescription blanks which are preprinted with the name of a proprietary preparation should be discouraged.
- When institutional prescription blanks are used, the prescriber should print his/her name, address, and DEA registration number on such blanks.
- Institutions should discourage the use of institutional prescription blanks for prescribing controlled substances. The prescriber should use his/her own prescription blanks in such instances.

Duty to Inform. The prescriber has the responsibility to inform patients of the effects of the prescribed drugs consistent with good medical practice and professional judgment. The patient has a corresponding duty to comply with the prescriber's directions for use of the prescribed medication.

Each of the professional organizations and the Drug Enforcement Administration has a responsibility to educate and inform the public on proper handling and use of controlled substances. The professions represented on the DEA/Practitioners Working Committee recognize that they have responsibilities to themselves, beyond legal minimum restraints. ■

DRIVERS' LICENSES FOR EPILEPTICS. A person subject to epileptic seizures may be licensed to drive a motor vehicle in Wisconsin on a temporary basis if:

(1) He submits with his application a certificate from a licensed physician recommending that a temporary driver's license be issued, and

(2) He is otherwise qualified to obtain a license.

The certificate is a form prepared by the Motor Vehicle Division and is designed to elicit medical information necessary to determine whether permitting the epileptic to drive would be a hazard to public safety.

To retain his license the epileptic must present a new certificate every six months.

The issuance of a temporary license is discretionary with the Motor Vehicle Division. A denial may be reviewed, however, by a special board. ■

Please refer to the June 1981 BLUE BOOK issue of the *Wisconsin Medical Journal* for information on the following related matters:

- Statement re prescribing habits with benzodiazepene class of drugs.
- Prescribing of therapies; *eg,* psychiatric, psychological, social work, physical therapy, occupational therapy, speech.

PREMARITAL EXAMINATIONS. Previous statutes requiring couples to have premarital (VD screening) examinations have been repealed. The physician's practice of giving complete physical examinations or representing complete physical examinations is no longer a mandatory requirement of the statutes. ■

PHYSICIAN GUIDELINES

Blood testing for alcohol and controlled substances

Introduction. No group is more closely involved in the tragic human toll caused by motor vehicle accidents than the medical profession. A major contributing factor to this toll is the driver whose driving abilities have been impaired by alcohol and/or controlled substances.

A major goal of traffic law enforcement is to get the alcohol or drug impaired driver off the road. Identification of such a driver frequently relies heavily on chemical tests to determine the level of alcohol or controlled substances in the driver's blood.

Before 1970 there were no statutory rules in effect on the subject of blood testing for this purpose. This absence of statutory law created confusion as to the rights and duties of law enforcement officers, drivers and physicians. The adoption of an implied consent law, which took effect May 1, 1970, since amended, helps clear up much of this confusion.

Physicians, who, in fulfilling their responsibilities in this field both as citizens and as professional men, have theretofore faced risk of liability of an undetermined scope in cooperating with law enforcement officers in obtaining blood specimens, now have a more solid basis upon which to act and a better definition of the scope of liability which they may face. The Council adopted these guidelines to assist physicians called upon to take such blood samples at the request of law enforcement officers.

Summary of Law. The theory of Wisconsin's implied consent law is that every person (including minors) using the state's roads is presumed to have consented to testing for alcohol and controlled substances if he is arrested for a violation involving driving under the influence of an intoxicant. (A preliminary breath test may be given before arrest, but this will not involve physician participation.) This presumption is overcome if the individual refuses to submit to the test, but refusal may result in suspension of his driving privileges and a severe sentence if he is convicted of driving under the influence of an intoxicant.

A person who is unconscious is presumed not to have withdrawn his consent to such chemical testing.

If the driver does not refuse to take a test, one may be given upon request of a traffic officer. The test may be blood, breath or urine, and the law enforcement agency administering the test is to designate which one shall be used.

The law says who may draw blood for testing purposes. This is a procedure which should be done only by or at the direction of a physician. When acting upon the request of a traffic officer to draw blood, the one drawing blood is immune from civil or criminal liability except for civil liability for negligence (malpractice) in doing so, providing the person has been arrested under certain specified statutes.

Recommended Guidelines. 1. *Obtain request/consent in writing.* If possible, the physician should obtain both the request to draw blood and a statement of arrest from the law enforcement officer and the driver's consent in writing. Where it is not possible to obtain one or the other, such as the situation in which the driver is unconscious, a special notation should be made to explain the absence of the signature. A proposed form for this purpose appears below.

2. *Do not withdraw blood if driver refuses.* The law provides that the person may refuse the request of a traffic officer to submit to a chemical test. The law

REQUEST/CONSENT FOR DRAWING BLOOD

The undersigned,_____a law enforcement officer of the State of Wisconsin, hereby requests _____, M.D., to draw blood, pursuant to Section 343.305, Wisconsin Statutes, from _____, whom the undersigned arrested for a violation of s. 346.63 (1) or a local ordinance in conformity therewith, or s. 346.63 (2) or 940.25, or s. 940.09 at _____, ___M., this date, for alleged criminal acts as referenced in Section 343.305 (2) involved in driving a motor vehicle while under the influence of an intoxicant. The blood drawn will be used to perform a clinical test to determine the alcohol and/or controlled substance level in the blood of the accused, which may be used as evidence against him.

Dated _____, at _____, ___M.

In the Presence of:

_____

_____ _____
Name

_____ _____
Title

The undersigned, _____, hereby consents to the drawing of blood from him by or under the direction of_____, M.D., pursuant to Section 343.305, Wisconsin Statutes. The undersigned understands that the blood is being drawn for the purpose of determining its alcohol and/or controlled substance content and that the results of this determination may be used in connection with his prosecution on criminal charges involving driving while under the influence of an intoxicant.

Dated _____, at _____, ___M.

In the Presence of:

_____

_____ _____
Name

If unable to obtain signatures on either the request or consent, above, please explain below:_____

_____

_____

_____
Name

Prepared by the Commission (now Committee) on Safe Transportation and adopted by the Council (now Board of Directors) of the State Medical Society of Wisconsin on May 10, 1970; revised June 1982. Reprint of article and reproducible form is available to SMS members at no charge under auspices of the CES Foundation; available to others at a cost of $3.00 for postage and handling to: CES Foundation, Attn: Drawing Blood Consent Form, PO Box 1109, Madison, Wis 53701; phone 257-6781 in Madison area or 1-800-362-9080 in Wisconsin. Copyright 1982 by the State Medical Society of Wisconsin.

does not define or limit what refusal may be and it is suggested that if the person being tested indicates refusal of the test in any way, the physician not withdraw the blood specimen.

3. *Establish procedures for meeting requests for tests.* Blood for testing should be drawn only by a physician or one acting under his direction. Since requests may come at unusual or inconvenient times, it is recommended that procedures be established in advance to meet these requests.

4. *Arrangements with law enforcement officers.* It is suggested that working arrangements be initiated in each community by local law enforcement officials with physicians, hospital medical staffs, or the county medical society. This would include the establishment of procedures for the preservation of blood samples for evidentiary use as well as coordination of procedures established for meeting requests for blood tests. Because of the relative ease of breath and urine tests compared to blood tests physicians should encourage local law enforcement agencies to employ breath or urine tests wherever possible.

5. *The physician remains liable for negligence.* While there is a general immunity from liability for physicians drawing blood under the law at the request of a traffic officer when the person has been placed under arrest, this immunity does not relieve them from responsibility for negligence in the performance of their professional acts. Negligence in this regard would include a determination whether the place in which the sample is to be drawn and the equipment used meet acceptable hygienic standards. If they do not, it is recommended that the physician not take the sample until proper hygienic conditions are met. ■

NARCOTICS

Annual Registration

A physician who desires to dispense, administer, or prescribe any controlled drug substance is required to have a Drug Enforcement Administration number (DEA no.). The initial registration application may be obtained from the Chicago Regional Office. The Regional Office of DEA in Chicago has informed the State Medical Society that DEA Headquarters will then annually mail a renewal application to each physician once initially registered.

Change of Residence

If you move, or change your place or places of business, you must notify the Drug Enforcement Administration, Registration Branch, PO Box 28083, Central Station, Washington, DC, 20005.

In Case of Death

The Regional Director, Drug Enforcement Administration, Chicago, Illinois, who has jurisdiction over the State of Wisconsin with respect to these matters, approved the following procedure in a communication to the State Medical Society:

> "The deceased physician's DEA number (Controlled Substances Registration Certificate), unused Government order forms and controlled drugs should be disposed of as soon as possible. The registration certificate and unused Government order forms (DEA-222 c) should be returned to the Drug Enforcement Administration, Registration Branch, PO Box 28083, Central Station, Washington, DC 20005. The controlled drugs may be disposed of by shipment, charges prepaid (shipment by registered mail is permissible) to the Regional Administrator, Drug Enforcement Administration, 219 South Dearborn, Suite 1800, Chicago, Illinois 60604, after the drugs have been inventoried on Form DEA-41, which can be obtained from any DEA office. One copy of the Form-41 will be returned to the sender upon receipt of the narcotic drugs. No remuneration will be made for the narcotics surrendered to DEA."

Preprinted Prescription Blanks

The Justice Department, Drug Enforcement Administration, reports that neither Federal law nor administrative regulations prohibits the printing of the physician's narcotic registration number on prescription blanks. ■

MEDICAL EXAMINING BOARD—Chapter Med 10

UNPROFESSIONAL CONDUCT DEFINED

Med 10.01 Authority and purpose. The definitions of this chapter are adopted by the medical examining board pursuant to the authority delegated by ss. 15.08 (5), 227.08, and 448.40, Stats., for the purposes of ch. 448, Stats.

Med 10.02 Definitions. (1) For the purposes of these rules:

(a) "Board" means the medical examining board.

(b) "License" means any license, permit, certificate, or registration issued by the board.

(2) The term "unprofessional conduct" is defined to mean and include but not be limited to the following, or aiding or abetting the same:

(a) Violating or attempting to violate any provision or term of chapter 448 of the statutes or of any valid rule of the board.

(b) Violating or attempting to violate any term, provision, or condition of any order of the board.

(c) Knowingly making or presenting or causing to be made or presented any false, fraudulent, or forged statement, writing, certificate, diploma, or other thing in connection with any application for license.

(d) Practicing fraud, forgery, deception, collusion, or conspiracy in connection with any examination for license.

(e) Giving, selling, buying, bartering, or attempting to give, sell, buy, or barter any license.

(f) Engaging or attempting to engage in practice under any license under any given name or surname other than that under which originally licensed or registered to practice in this or any other state. This subsection does not apply to change of name resulting from marriage, divorce, or order by a court of record.

(g) Engaging or attempting to engage in the unlawful practice of medicine and surgery or treating the sick.

(h) Any practice or conduct which tends to constitute a danger to the health, welfare, or safety of patient or public.

(i) Practicing or attempting to practice under any license when unable to do so with reasonable skill and safety to patients.

(j) Practicing or attempting to practice under any license beyond the scope of that license.

(k) Offering, undertaking, or agreeing to treat or cure a disease or condition by a secret means, method, device, or instrumentality; or refusing to divulge to the board upon demand the means, method, device, or instrumentality used in the treatment of a disease or condition.

(l) Representing that a manifestly incurable disease or condition can be or will be permanently cured; or that a curable disease or condition can be cured within a stated time, if such is not the fact.

(m) Knowingly making any false statement, written or oral, in practicing under any license, with fraudulent intent; or obtaining or attempting to obtain any professional fee or compensation of any form by fraud or deceit.

(n) Wilfully divulging a privileged communication or confidence entrusted by a patient or deficiencies in the character of patients observed in the course of professional attendance, unless lawfully required to do so.

(o) Soliciting or attempting to solicit patients, directly, indirectly, or by agents.

(p) Administering, dispensing, prescribing, supplying, or obtaining controlled substances as defined in s. 161.01 (4), Stats. otherwise than in the course of legitimate professional practice, or as otherwise prohibited by law.

(q) Having a license, certificate, permit, or registration granted by another state to practice medicine and surgery or treat the sick limited, restricted, suspended, or revoked, or having been subject to other disciplinary action by the licensing authority thereof.

(r) Conviction of any crime which may relate to practice under any license, or of violation of any federal or state law regulating the possession, distribution, or use of controlled substances as defined in s. 161.01 (4), Stats. A certified copy of a judgment of a court of record showing such conviction, within this state or without, shall be presumptive evidence thereof.

(s) Prescribing, ordering, dispensing, administering, supplying, selling, or giving any amphetamine, sympathomimetic amine drug or compound designated as a schedule II controlled substance pursuant to the provisions of ch. 161 Stats. to or for any person except for the treatment of narcolepsy, or for the treatment of hyperkinesis, or for the treatment of drug induced brain dysfunction, or for the treatment of epilepsy, or for the differential diagnostic psychiatric evaluation of depression, or for the treatment of depression shown to be refractory to other therapeutic modalities, or for the clinical investigation of the effects of such drugs or compounds in which case an investigative protocol therefore shall have been submitted to and reviewed and approved by the board before such investigation has been begun. ■

MEDICAL EXAMINING BOARD—
Chapter Med 8

PHYSICIAN'S ASSISTANTS

Med 8.01 Authority and purpose. The rules in this chapter are adopted by the medical examining board pursuant to the authority delegated by ss. 15.08 (5), 227.08, 444.04 (1) (f) and 448.40, Stats., and govern the certification and regulation of physician's assistants.

Med 8.02 Definitions. (1) "Board" means the medical examining board.

(2) "Council" means the council on physician's assistants.

(3) "Certificate" means documentary evidence issued by the board to applicants for certification as a physician's assistant who meet all of the requirements of the board.

(4) "Educational program" means a program for educating and preparing physician's assistants which is approved by the board.

(5) "Individual" means a natural person, and does not include the terms firm, corporation, association, partnership, institution, public body, joint stock association, or any other group of individuals.

(6) "Supervision" means to co-ordinate, direct, and inspect continually the accomplishments of another, or to oversee with powers of direction and decision the implementation of one's own or another's intentions.

(7) "Patient services" means any or all of the following:

(a) The initial approach to a patient of any age in any setting to elicit a personal medical history, perform an appropriate physical examination, and record and present pertinent data in a manner meaningful to the physician.

(b) Performing, or assisting in performing, routine diagnostic studies as appropriate for a specific practice setting.

(c) Performing routine therapeutic procedures including but not limited to injections, immunizations, and suturing and care of wounds.

(d) Instructing and counseling patients on physical and mental health including but not limited to diet, disease, treatment, and normal growth and development.

(e) Assisting the physician in the institutional setting by assisting at surgery, making patient rounds, recording patient progress notes, compiling and recording detailed narrative case summaries, and accurately writing or executing standing orders or other specific orders following consultation with and at the direction of the supervising physician. Countersignature of records must be consistent with institutional regulations.

(f) Assisting in the delivery of services to patients by reviewing and monitoring treatment and therapy plans.

(g) Independently performing evaluative and treatment procedures necessary to provide an appropriate response to life threatening emergency situations.

(h) Facilitating referral of patients to other appropriate community health facilities, agencies, and resources.

Med 8.03 Council: powers, meetings, records. The council shall exercise such powers as are or may be provided to it by the laws of the state of Wisconsin pertaining to the education, certification, and regulation of physician's assistants. The council shall propose to the board such rules not inconsistent with the law, as it deems necessary and proper for the execution and enforcement of such laws. The council shall meet at least 4 times in each calendar year. The chairman, or other presiding officer of the council, may call special meetings thereof when, in the judgement of such chairman or other presiding officer, circumstances or functioning of the council so require. The chairman, or other presiding officer of the board, may call special meetings of the council when, in the judgement of such chairman or other presiding officer, circumstances or functioning of the council or of the board so require. The secretary shall maintain an accurate record of all proceedings of the council.

Med 8.04 Certifying educational programs. The board shall conduct an investigation prior to approving any educational program which prepares physician's assistants. The examining board may designate an agent and one or more examining board members and one or more council members to conduct a portion or all of such investigation to determine the facts upon which the examining board shall make its decision. Any party aggrieved by the decision of the examining board under this section may, within 20 days of notice thereof, apply for a formal hearing before the board or an agent duly appointed to sit for the board. The decision of the board shall comply with s. 227.13, Stats., and may be reviewed as provided in s. 227.16, Stats.

Med 8.05 Practice: scope and limitations. In providing patient services the entire practice of a physician's assistant shall be under the supervision of a licensed physician. The scope of practice of a physician's assistant shall not exceed the definitions of "patient services" as set forth in Med 8.02 (7) Wis. Adm. Code, nor the physician's assistant's training

and experience, nor the scope of practice of the supervising physician. No physician's assistant shall redelegate a task delegated to such physician's assistant by the supervising physician.

Med 8.06 Employe status. No physician's assistant shall be self employed. If the employer of a physician's assistant is other than a licensed physician, such employer shall provide for and not interfere with the supervision required in Med 8.05 Wis. Adm. Code.

Med 8.07 Employment limitation: supervising physician responsibilities. (1) No physician may supervise more than 2 physician's assistants, but a physician's assistant may be supervised by more than one physician. In the case of exceptions to this rule, a written plan for the supervision of more than 2 physician's assistants by a licensed physician must be filed with, reviewed, and recommended for approval by the council, and approved by the board.

(2) Another licensed physician may be designated by the supervising physician to supervise a physician's assistant for periods not to exceed 8 weeks per year. Except in an emergency, such designation shall be made in writing to the substitute supervising physician and to the physician's assistant, and must be executed and a copy thereof filed with the council prior to the supervising physician's absence.

(3) A physician's assistant may practice on premises away from the main office of the supervising physician or an institution where the supervising physician has staff privileges, providing that the supervision required in Med 8.02 (6), Wis. Adm. Code, is maintained. The physician's assistant must be able to contact either at first hand or by telephone, radio or television the supervising physician or designated substitute physician within 15 minutes at all times. The physician shall review and countersign all notes made by the physician's assistant at least weekly. A supervising physician must visit locations attended by a physician's assistant no less than every 3 months. Patients in locations other than the location of the supervising physician's main office shall be attended personally by the physician consistent with their medical needs.

Med 8.08 Qualification, application, examination, re-examination. (1) To be qualified for admission to examination for certification as a physician's assistant in this state, an applicant must supply evidence satisfactory to the board that the applicant:

(a) Is of good professional character.

(b) Has successfully completed a formal physician's assistant educational program approved by the board. Until January 1, 1980, the board may waive this requirement for an applicant who has been employed in practice as a physician's assistant, as defined in these rules for 24 consecutive months during the 3 calendar years preceding January 1, 1975.

(2) Every person applying for certification as a physician's assistant shall make application therefor on forms provided for this purpose by the board and shall submit to the board the following:

(a) A completed and verified application form.

(b) An unmounted photograph, approximately 8 by 12 cm., of the applicant taken not more than 60 days prior to the date of application and bearing on the reverse side the statement of a notary public that such photograph is a true likeness of the applicant.

(c) A verified statement that the applicant is familiar with the state health laws and the rules of the department of health and social services as related to communicable diseases.

(3) Having complied with sub. (2), the applicant shall be examined. Examination may be both written and oral. The council shall advise the board as to content of the examinations required under this subsection and passing grades therein, and the board shall provide for such content and such passing grades. In lieu of its own examinations, the board may make such use as it deems appropriate of examinations prepared, administered, and scored by national examining agencies. The board designates the council as its agent for conducting examinations.

(4) The board will notify each applicant found eligible for examination of the time and place scheduled for that applicant's examinations. Failure of an applicant to appear for examinations as scheduled will void that applicant's application and require the applicant to reapply for certification, unless prior scheduling arrangements have been made with the board by the applicant. At the opening of the examinations, each applicant will be assigned a number which shall be used by the applicant on all examination papers, and neither the name of the applicant nor any other identifying marks shall appear on any such papers. At the opening of the examinations the proctor will read and distribute to the assembled applicants the rules of conduct to be followed during the course of the examinations. Any violation of these rules of conduct by any applicant will be cause for the board to terminate the examination of such applicant and to exclude such applicant from continuing the examinations, and will also be cause for the board to find that such applicant has failed the examinations.

(5) An applicant who fails to achieve a passing grade in the examinations required under this chapter may apply for re-examination on forms provided for that purpose by the board. For each such re-examination the application therefor shall be accompanied by the re-examination fee. An applicant who fails to achieve a passing grade in the examinations required under this chapter may be re-examined twice at not less than 4 month intervals, and if such applicant fails to achieve a passing grade on the second such re-examination, that applicant shall not be admitted to

further examination until such applicant reapplies for certification and also presents to the board evidence of such further professional training or education as the board may deem appropriate in such applicant's specific case.

(6) There is no provision for waiver of examination or for reciprocity with other licensing jurisdictions under these rules.

(7) At the time of initial certification and at the time of each biennial registration thereafter, each physician's assistant shall list with the board the name and address of the supervising physician and shall also notify the board of any change of supervising physician within 20 days following such change.

Med 8.09 Exclusions. None of the provisions of this chapter shall be construed to permit the independent prescribing or dispensing of any drug, or the practice of acupuncture in any form, by any physician's assistant.

Med 8.10 Temporary certificate prior to permanent certificate. (1) An applicant for certification to practice as a physician's assistant may apply to the board for a temporary certificate to practice as a physician's assistant if the applicant:

(a) Is a graduate of an approved school and applies for the temporary certificate not less than 30 days prior to the date set for the national certifying examination for primary care physician's assistants; or

(b) Provides proof of having successfully completed the national certifying examination for primary care physician's assistants, and applies for the temporary certificate not less than 30 days prior to the date set by the board for holding its next oral examinations for certification as a physician's assistant.

(2) Following review by a council member of the applications and required documents for permanent and temporary certification and a finding by the member that the applicant is qualified for admission to the examination for permanent certification to practice as a physician's assistant, the council member, on behalf of the board, may issue a temporary certificate to practice as a physician's assistant to the applicant.

(3) The fee specified in s. 440.05 (6), Stats., must accompany the application for the temporary certificate and all remittances must be made payable to the Wisconsin medical examining board.

(4) (a) Except as provided in par. (b), a temporary certificate to practice as a physician's assistant expires 30 days after the completion of the next oral examination for permanent certification or on the date the board grants or denies the holder of the temporary certificate a permanent certificate, whichever is later.

(b) A temporary certificate expires on the first day of an oral examination for a permanent certificate if the holder of the temporary certificate is required to take the oral examination and fails to apply for the examination.

(5) A temporary certificate to practice as a physician's assistant shall be issued only once to each applicant. ■

ATTORNEY GENERAL'S OPINION

Relating to the practice of physical therapy

IN APRIL Attorney General Bronson C La Follette responded to a request of Walter L Washburn, MD, secretary of the State Medical Examining Board in the Department of Regulation and Licensing, for an opinion in regard to two issues relating to the practice of physical therapy which arise under the fee splitting statute, sec. 448.08(1), Stats., and the professional service corporation statute, sec. 180.99(2), Stats. The Attorney General's opinion follows:

* * *

You (Doctor Washburn) state there are a number of instances in the State of Wisconsin where a physical therapist has a salaried relationship with a service corporation in which the "field of endeavor" within the meaning of sec. 180.99(2), Stats., is the practice of medicine and/or surgery. The service corporation, made up of licensed physicians, pays the salary of the physical therapist and refers patients to the physical therapist for therapy in accordance with the physicians' directions. The patient is then billed by the service corporation and the fees are ultimately collected by and paid to the service corporation. You further indicate that in this way the fees for the therapy are split between the therapist's salary and the corporation's income. You question whether this arrangement violates the fee splitting provisions of sec. 448.08(1), Stats., which read as follows:

> FEE SPLITTING. Except as otherwise provided in this section, no person licensed or certified under this chapter may give or receive, directly or indirectly, to or from any person, firm or corporation any fee, commission, rebate or other form of compensation or anything of value for sending, referring or otherwise inducing a person to communicate with a license in a professional capacity, or for any professional services not actually rendered personally or *at his or her direction.*

The original "fee splitting" statute was enacted by ch. 570, Laws of 1913, and became sec. 4431b of the statutes. The Attorney General described the purpose of this law in 3 Op. Att'y Gen. 218, 219 (1914) as follows:

> The object of this law, as I understand it, was to prevent the practice, which was alleged to have grown up in this state, of physicians and surgeons in the larger cities, paying fees or commissions to the country physicians and surgeons for inducing or advising patients to submit to operations or treatments by such city physicians and surgeons. Such fees or commissions were not for any services rendered to the patient, but purely a service rendered to the other physicians or surgeons in the way of sending them this business.

That construction of the law was strengthened by ch. 469, Laws of 1915, and subsequent opinions of the Attorney General at 6 Op. Att'y Gen. 306 (1917), and 24 Op. Att'y Gen. 580 (1935). In 6 Op. Att'y Gen. 306 (1917), the question raised concerned a proposal being promoted by the "Wisconsin Committee for Medical Preparedness" which related to physicians enlisting for service in World War I. The committee was asking physicians to sign a statement including the following paragraph:

> Recognizing the patriotism of those members of the Medical Profession who volunteer for the service of the U.S. Government, I agree to remit to my County Secretary one third of such fees as I receive for attendance on patients of doctors ordered into active service for the Government, these remittances to be held in trust for the volunteer or turned over to his family.

The question was whether such an agreement violated the "fee splitting" statute.

In finding no fee splitting after reviewing the earlier 1914 opinion, the Attorney General pointed out that the statute required an element of advice or inducement, and of fee splitting as compensation for such advice or inducement, before an offense of "fee splitting" would be present. It is to be noted that the present statute, sec. 448.08(1), Stats., still contains the inducement requirement. In other words, it was then illegal and is still illegal for a physician to share in a fee charged for services of another physician merely because the sharing physician has referred or induced a patient to communicate with another physician who provided the professional services. Since ch. 383, Laws of 1975, the fee splitting statute is applied to any persons licensed under ch. 448, Stats., which includes physical therapists.

In construing sec. 448.01(1), Stats., we must remember that the statute provides for a criminal penalty of $10,000.00 or imprisonment for not more than nine months or both and therefore the statute must be strictly construed. *State v. Wilson,* 77 Wis. 2d 15, 252 N.W.2d 64 (1977), and *Chapman v. Zakzaska,* 273 Wis. 64, 76 N.W.2d 537 (1956).

The statute prohibits two things. First, it prohibits the receiving of any fee for sending, referring or otherwise inducing a person to communicate with another licensee. Secondly, it prohibits any licensee under the chapter from receiving any fee "for any professional services not actually rendered personally or at his or her direction." Thus, where the physician participates with or directs the physical therapist in rendering treatment, both the physical therapist and the physician may receive compensation for the services rendered.

Ordinarilly, after the physician has referred a patient to a physical therapist pursuant to sec. 448.04(1) (e), Stats., the physician would not provide further direction in the carrying out of the physical therapy treatment and, therefore, the physician could not make a separate charge for that treatment. However, this does not mean that where the physical therapist is employed by a medical professional service corporation, the billings for the services of the physical therapist could not include amounts for salary, fringe benefits, and operating expenses in connection with the operation of the corporation. There would also be no violation of the fee splitting statute, sec. 448.08(1), Stats., where the physician, through a service corporation owned by that physician, bills the patient for his own services and for the services of the employed physical therapist.

Section 448.08(2), Stats., requires that anyone licensed under ch. 448, Stats., who renders any medical service

> to any patient, physician or corporation, or to any other institution or organization of any kind, including a hospital, for which a charge is made to such patient receiving such service . . . shall, . . . render an individual statement or account of the charges therefor directly to such patient, distinct and separate from any statement or account by any physician or other person . . .

In my opinion this separate billing requirement is satisfied under the above circumstances where the billing identifies the physician and physical therapist pro-

CAPSULE OPINION OF ATTORNEY GENERAL

There is no violation of the "fee splitting" statute, sec. 448.08(1), Stats., where a physician, through a service corporation owned by the physician, bills the patient for his own services, and that of physical therapist employed by the corporation, provided the billing states an accurate dollar figure for the respective services.

A medical professional service corporation is not in violation of sec. 180.99(2), Stats., when physical therapists are on the staff of the corporation.

viding the services and states an accurate dollar figure for the respective services.

In your second question you ask whether a medical professional service corporation created under sec. 180.99(2), Stats., is in violation of that statute when physical therapists are on the staff of that medical professional service corporation. You say the issue arises because the "field of endeavor" for the service corporation is listed as the "practice of medicine and/or surgery." Although there is no definition in the statutes of "field of endeavor," it does not appear that the Legislature intended to prohibit a medical service corporation formed for "practice of medicine and/or surgery" from employing nurses, physical therapists, podiatrists or other licensed individuals whose professions are supportive of the practice of medicine and surgery. Indeed, the last sentence of sec. 180.99(8), Stats., and the last sentence of sec. 180.99(9), Stats., would support a construction that the Legislature intended that the term "field of endeavor" be liberally construed and that the terms "officers, employees or agents" used in sec. 180.99(2), Stats., include physical therapists employed by such corporation.

Accordingly, it is my opinion that the employment of physical therapists under the circumstances set out in your opinion request would not violate sec. 180.99, Stats. ■

GOOD SAMARITAN LAW

The Legislature has broadened the immunity provided by the Wisconsin Good Samaritan Law to cover any person rendering aid at the scene of an emergency. First enacted to protect physicians, these laws are common throughout the United States. They are designed to encourage prompt care for persons who are injured or become ill away from normal locations where treatment is given.

The scene of an emergency does not include a hospital or physician's office. Persons employed and trained to render emergency care, acting for compensation and within the scope of their employment are not protected under the law. ■

FDA's toll-free number

The Food and Drug Administration has a toll-free number for physicians to call to report problems with drugs, medical devices, and *in vitro* diagnostic products. The purpose is to help the FDA determine when a product poses a significant potential health hazard. Problems with which the FDA is concerned are hazardous or potentially hazardous products, mislabeling, incomplete or confusing instructions, erroneous information, nonsterile products, packaging errors, and other quality control errors. The number to call is: **1·800·638·6725.**

WORKER'S COMPENSATION AND THE PHYSICIAN

MOST WISCONSIN PHYSICIANS become involved with treatment of patients covered by Worker's Compensation, which provides payment of compensation for disability, and for medical expenses necessary because of injury or illness arising out of employment.

The State Medical Society's Committee on Environmental and Occupational Health, which maintains liaison with the Worker's Compensation Division, offers the following helpful information:

Filing reports. Filing reports is a direct responsibility of any physician who treats patients under the Worker's Compensation Program. WC-16 Medical Report on Industrial Injury is to be completed on a work-related injury or illness when the disability exceeds three weeks or when any permanent disability results therefrom. WC-16 is available from the insurance carrier or from WC Division. Information reported is used by the WC Division to determine the amount of compensation payable to the disabled worker.

Estimating disability. Learn to estimate disability according to standards set up by the WC Division. Other standards or schedules are fine for physicians' own information, but only the WC Division's standards are authoritative in Wisconsin (see "New Rules Established for Estimating Disabilities in Workmen's Compensation Cases" which appeared in the June 1975 BLUE BOOK, pp 43-45).

Completing reports. Complete report forms carefully and fully. Learn terminology of the statutes concerning compensable employment disability.

Submitting reports. Submit reports promptly. Delay may mean withholding of compensation to the injured employe and professional fees to the physician. An unexpected misfortune may place the employe in urgent need of compensation.

Payment for reports. Occasionally physicians request reimbursement for preparing and filing reports. The Committee on Environmental and Occupational Health wishes to restate the following principles:

—Simplified reports including initial reports, progress reports, and final reports: No charge.
—WC-16 Report: No charge.
—When a special report, such as the WC-16B, is requested by the WC Division, or the insurance carrier requires an extensive or extra-ordinary report in lieu of a simplified report, a reasonable charge for preparation and filing is appropriate.

Don't be afraid to ask questions. Contact either the State Medical Society or K Sue Mattka of the Worker's Compensation Division, 201 East Washington Ave, Box 7901, Madison, Wis 53707 (tel 608/266-1340).

Standard casualty medical report form

The State Medical Society Board of Directors reaffirmed its position March 13, 1982 that the standard casualty medical report form should be completed without charge.

Under terms of a 1963 agreement between the State Medical Society and the Wisconsin Claims Council, a doctor who files a standard short report form without charge receives insurance company support of his or her financial interest at the time of payment.

According to Sterling Schallert of the Wisconsin Claims Council, the casualty insurance company agrees to stand up for the doctor's right to receive payment when the claim is settled. Although there are 45 Claims Council members, this "gentlemen's agreement" is reportedly practiced by all of the casualty companies doing business in Wisconsin.

The casualty companies and the State Medical Society devised the form (appearing adjacent to this article) to protect the interests of doctors, companies, and insureds. Because it is the standard report form recognized by the Society, it cannot be changed by any insuror other than to add the logo of the insurance company requesting the information.

The Claims Council recently presented information to the SMS Physicians Alliance Commission indicating that an increasing number of physicians using the form are requesting a fee for its completion. Perhaps these physicians were unaware that the insurance company would protect their financial interests to receive direct payment at the time of claim settlement if they filed without charge. The Physicians Alliance Commission recommended to the Board of Directors that physicians be reminded of the availability of the form and the agreement with the Claims Council.

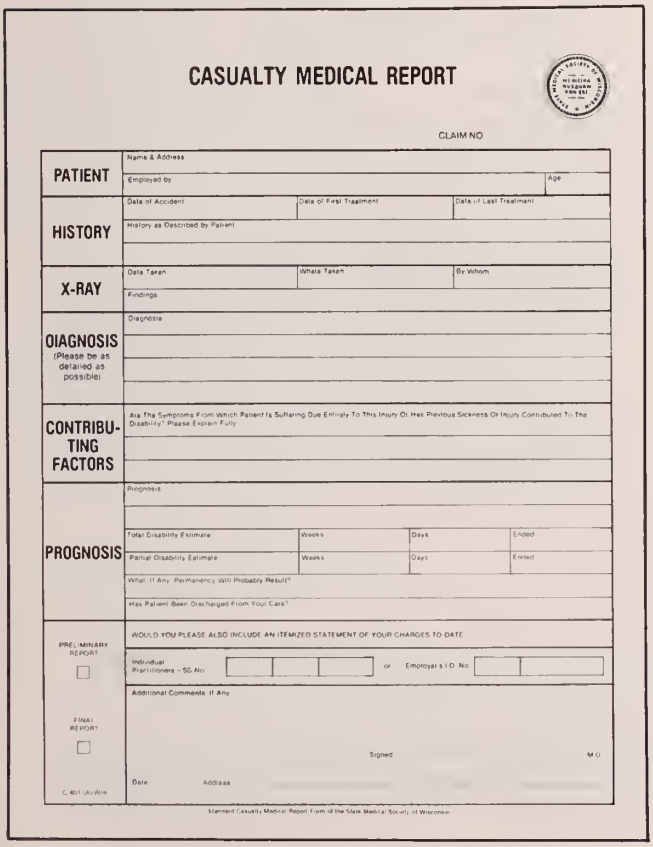
Physicians are cautioned that this agreement only applies to the short form. If a physician is asked to file a lengthy narrative report by the insurance company, he or she should expect payment for this additional service.

The brief report form contains questions about the patient's history, his employment, and any past illness which might have contributed to the sickness or injury. Five questions relate to prognosis and one to diagnosis.

The Claims Council stresses that this agreement is not an absolute guarantee of direct payment to the physicians. Rather, it is an understanding to support the doctor's financial interest in the claim. The Claims Council's record is very good in this area.

Although the Board of Directors originally ordered a distribution of the report forms to all member physicians, newly licensed physicians and those who have moved into the State since this effort was initiated understandably may not be aware of it.

Physicians usually get these forms from the insurance company involved. ■



CASUALTY MEDICAL REPORT

CLAIM NO

PATIENT — Name & Address; Employed by; Age

HISTORY — Date of Accident; Date of First Treatment; Date of Last Treatment; History as Described by Patient

X-RAY — Date Taken; Whats Taken; By Whom; Findings

DIAGNOSIS (Please be as detailed as possible) — Diagnosis

CONTRIBUTING FACTORS — Are The Symptoms From Which Patient Is Suffering Due Entirely To This Injury Or Has Previous Sickness Or Injury Contributed To The Disability? Please Explain Fully

PROGNOSIS — Prognosis; Total Disability Estimate; Weeks; Days; Ended; Partial Disability Estimate; Weeks; Days; Ended; What If Any Permanency Will Probably Result?; Has Patient Been Discharged From Your Care?

PRELIMINARY REPORT ☐ — WOULD YOU PLEASE ALSO INCLUDE AN ITEMIZED STATEMENT OF YOUR CHARGES TO DATE; Individual Practitioners – SS No. or Employer's I.D. No.

FINAL REPORT ☐ — Additional Comments If Any; Signed; M.D.; Date; Address

Standard Casualty Medical Report Form of the State Medical Society of Wisconsin

The Abused Child Law

Abuse of children by parents and others can be found at all economic, educational, and social levels. The cumulative effect of repeated beatings or other forms of severe abuse, which may include sexual exploitation, physical crippling, brain damage or even death, must be prevented.

The Abused Child Law makes reporting of suspected cases of child abuse mandatory by physicians and others dealing with children. They are required to report cases of suspected child abuse. The law further provides that the reports be made to the city police departments, sheriffs, and county child welfare agencies. Civil as well as criminal immunity from suit is granted where a report is made in good faith. Child abuse has been made a Class E felony (punishable by a fine up to $10,000 and imprisonment up to two years).

The actions of the Legislature have immeasurably increased the probabilities that perpetrators of abuse will be identified and will receive rehabilitative help while the abused child will be extended protection from further abuse.

Relevant portions of the law, quoted from the Wisconsin Statutes, appeared in the June 1979 *Blue Book* issue. ■

MUST A
Wisconsin Physician Report?

1. Deaths?

The Wisconsin Statutes requires that the following deaths must be reported *immediately* to the sheriff, police chief, or coroner of the county in which such death occurred:

a. All deaths in which there are unexplained, unusual, or suspicious circumstances.
b. All homicides.
c. All suicides.
d. All deaths following an abortion.
e. All deaths due to poisoning, whether homicidal, suicidal or accidental.
f. All deaths following accidents, whether the injury is or is not the primary cause of death.
g. When there was no physician in attendance within 30 days preceding death.
h. When a physician refuses to sign the death certificate.
i. When a physician cannot be obtained within 24 hours of death.

Violations of the above are punishable by fine or imprisonment.

2. Treatment of automobile accident injuries?

No, unless there is a death.

3. Drowning?

Yes.

4. Gun shot wounds?

No, except where death results.

5. Hunting accidents?

No, except where death results.

6. Industrial accidents?

No, except where death results.

7. Industrial diseases?

Yes, to the Division of Health, Department of Health and Social Services, for diseases as required by statute or regulation.

8. Suicide attempts?

No; only death by suicide is reportable.

9. Sending of corpses to undertaker?

Yes. *Before* a physician sends a corpse to a funeral director, undertaker, mortician, or embalmer, he *must* notify the next of kin or a person who may be chargeable with the funeral expenses. There is a penalty for violation of this requirement.

10. Live births?

Yes, you must file with the city health officer or county register of deeds, as appropriate, a certificate for all births attended by you within five (5) days. Failure to file within the time period makes fees for medical services unlawful. Additionally, the physician must separately report congenital defects or physical deformities of a newborn observed within 24 hours of birth. Such cases are reportable to the Division of Health, Department of Health and Social Services.

11. Communicable diseases?

Yes, to local health authorities, except for polio which must be reported locally and to the Division of Health, Department of Health and Social Services, 1 West Wilson Street, PO Box 309, Madison, Wisconsin 53701.

12. Venereal diseases?

Yes, to the Division of Health, Department of Health and Social Services, 1 West Wilson Street, PO Box 309, Madison, Wisconsin 53701.

13. Tuberculosis?

Yes, to your local Board of Health.

14. Chronic alcoholics?

No, even if you know or believe it probable that they are driving automobiles.

15. Epileptics?

No. But see article elsewhere in this issue.

16. Drug addiction?

No.

17. Abused or neglected children?

Yes. The law requires reports of "abused" (including sexual exploitation) or "neglected" (those not receiving food, clothing, shelter or care, including medical care so as to "seriously endanger" the child's health) children or those with exceptional educational needs (see article in June 1979 BLUE BOOK issue, page 28.) Wilful failure to report may subject a physician to a penalty; good faith reports provide immunity.

The foregoing list incorporates questions most commonly asked, and is by no means a complete list of all that the statutes or department rules of the state require by way of reports from physicians.

The law prohibits a physician from disclosing, except as specifically required or authorized by law, any information which he acquired in attending a patient and which is necessary for him to treat that patient. Information provided to the Division of Health which relates to personal facts about a patient may be used only for statistical or summary purposes or anonymously except as its disclosure may be necessary to provide services for the patient.

Some considerations before opening a physician's practice

WHEN BEGINNING a medical practice, whether starting a new one or joining an existing group, there are many matters that should be considered before seeing your first patient. The following check list has been developed to itemize major tasks or decisions a physician should consider prior to that time. Depending upon the type of practice, some may not apply; however, if this list is used, the majority of items will be covered.

- ☐ *Discuss practice location with spouse* (type of community desired, location, size, hospitals, school system, cultural opportunities).
- ☐ *Office facilities* (rent—negotiate lease; own—negotiate and close purchase).
- ☐ *Determine office layout and size.*
- ☐ *Furniture and equipment* (office—chairs, desks, calculators, computer; waiting room—chairs, tables, lamps; examining room—desk, chairs, exam table, medical equipment and supplies).
- ☐ *Obtain license to practice medicine.*
- ☐ *Obtain federal narcotics number.*
- ☐ *Develop employment contract.*
- ☐ *Partnership agreement or service corporation articles.*
- ☐ *Hospital staff privileges.*
- ☐ *Choose advisors* (accountant, lawyer, banker, management consultant, insurance agent, real estate broker, investment counsel).
- ☐ *Obtain necessary insurance coverage* (business—professional liability, Worker's Compensation, general liability, umbrella [business/personal], employee fidelity bond; personal—health, life, disability income/income protection, home owners, auto).
- ☐ *Determine office hours based on community needs.*
- ☐ *Apply for federal and state employer identification (ID) numbers.*
- ☐ *Apply for federal and state unemployment compensation tax ID numbers.*
- ☐ *Determine support staff needed, interview and hire.*
- ☐ *Obtain necessary financing.*
- ☐ *Develop financial systems* (determine fees, accounting system, billing, system, statement format, collections and receivable management, consider credit card payments by patients, internal controls).
- ☐ *Announcements to local physicians, pharmacists, general public* via newspaper, telephone directory, individually mailed announcements and calling and appointment cards.
- ☐ *Open checking account(s).*
- ☐ *Learn community resources* (hospitals, schools, pharmacies, social services, rehabilitation services).
- ☐ *Arrange for utilities* (telephone, electricity, gas/oil, water).
- ☐ *Telephone answering service.*
- ☐ *Arrange for coverage during off hours.*
- ☐ *Order necessary office forms* (letterhead, envelopes, RX forms, accounts receivable statements, third-party claim forms or uniform claim forms).
- ☐ *Arrange for lab and x-ray services.*
- ☐ *Obtain good debt collection service.*
- ☐ *Repay student loans on timely basis.*
- ☐ *All employees must complete federal Form W-4 and state Form WT-4* (withholding allowance certificates).
- ☐ *Memberships* (become involved in: county and state medical societies, AMA, specialty societies, local service or business groups, hospital staff activities).

The AMA has a regular schedule of "Starting Your Own Practice" workshops which also provide much information on this subject.

This checklist is intended to provide the most common matters a physician should consider when starting a practice. It is not inclusive in every instance since individual circumstances require attention to matters unique to that situation.

Physicians may also contact the State Medical Society in Madison for additional information: (608)257-6781, or toll-free in Wisconsin 1-800-362-9080. Office location: 330 East Lakeside St, Madison 53715 (Lakeside Street intersects John Nolen Drive at the signal lights just before crossing the "causeway" over Lake Monona to Downtown Madison, from the South Beltline near the Coliseum).

"Blue Book" good reference source

Whether opening a practice for the first time or moving a practice to Wisconsin, physicians will find valuable information in the annual "Blue Book" issue of the *Wisconsin Medical Journal,* the official publication of the State Medical Society of Wisconsin. This is a reference source on medicolegal, socioeconomic, legislative, governmental matters of direct concern to the physician. It also is a reference source on State Medical Society organizational structure, other related organizations, and state government agencies.

To obtain a copy contact the *Wisconsin Medical Journal,* PO Box 1109, Madison, Wis 53701, or phone State Medical Society offices in Madison as noted above. ■

Some considerations in the closing of a physician's practice

WHILE THERE ARE NO formally slated rules for closing a medical practice, there are several important items which should be considered and planned in advance. The list given below is not complete but the State Medical Society of Wisconsin believes it will be helpful.

1. Notification of patients

Patients should be given adequate notice, a minimum of three months is suggested, in writing that you plan to close your office and on what date so that they will have sufficient time to obtain another physician. It is also suggested that, in the letter of notice to the patients, you enclose a form for the patient to sign authorizing the release of records should they wish to request that a copy of their records be sent to the new physician of their choice. A list of all patients notified should be retained in your files.

You can save postage, in the case of current patients, by inserting the letter with a monthly statement or billing; letters to other patients will have to be mailed separately.

You also may wish to place an announcement in one or more local newspapers.

2. Retention of medical records

(a) Medical records, including case histories, treatment records, x-rays, laboratory reports, correspondence with physicians and others, should not be destroyed until the statute of limitations has expired with regard to each patient. This is because the physician's record and liability insurance policies could be your chief source of defense in a future law suit.

The Statute of Limitations has been revised to allow actions involving adults to be initiated within three years of the occurrence or one year from discovery of the injury but not later than five years from the occurrence. Actions involving minors are bound by this limitation, or age 10 years, whichever is later. Possession of the policy will be invaluable or you may face the defense alone at your own expense.

(b) The patient has a general right to know what is in his medical records and thus you should make it known where such records can be obtained. Such records generally should not be given to the patient, but should be forwarded to another physician of the patient's choice with the consent and at the request of the patient, in writing.

(c) The Wisconsin Statutes relating to the examination or inspection of medical records on patient authorization read:

> **"804.10 (4).** Upon receipt of written authorization and consent signed by a person who has been the subject of medical care or treatment, or in case of death of such person, signed by the personal representative or by the beneficiary of an insurance policy on the person's life, the physician or other person having custody of any medical or hospital records or reports concerning such care or treatment, shall forthwith permit the person designated in such authorization to inspect and copy such records and reports. Any person having custody of such records and reports who unreasonably refuses to comply with such authorization shall be liable to the party seeking the records or reports for the reasonable and necessary costs of enforcing the party's right to discover."

3. Disposal of drug stocks

The Regional Administrator of the Drug Enforcement Administration, Chicago, Illinois, has jurisdiction over the State of Wisconsin with regard to disposal of unused controlled substances. The following procedure has been approved as a guide to physicians:

> "The physician's DEA number (Controlled Substances Registration Certificate), unused Government order forms and controlled drugs should be disposed of as soon as possible. The registration certificate and unused Government order forms (DEA-222 c) should be returned to the Drug Enforcement Administration, Registration Branch, Post Office Box 28083, Central Station, Washington, D.C. 20005. The controlled drugs may be disposed of by shipment, charges prepaid (shipment by registered mail is permissible) to the Regional Administrator, Drug Enforcement Administration, 219 South Dearborn, Suite 1800, Chicago, Illinois 60604, after the drugs have been inventoried on Form DEA-41, which can be obtained from any DEA office. One copy of the Form-41 will be returned to the sender upon receipt of the narcotic drugs. No remuneration will be made for the narcotics surrendered to DEA."

Forms and additional information may be obtained from the Milwaukee District Office: Drug Enforcement Administration, 517 East Wisconsin Avenue, Room 228A, Milwaukee, Wisconsin 53202; (414) 224-3395.

Instructions on the disposal of non-narcotic drugs in the possession of the physician may be obtained from the Wisconsin Pharmacy Examining Board, 1400 East Washington Avenue, Madison, Wisconsin 53702.

4. Sale of medical practice

(a) If you are selling your practice, you should make certain that the buyer is a physician licensed, or eligible to be licensed, in Wisconsin. This information can be obtained from the State Medical Society or the Wisconsin Department of Regulation and Licensing.

(b) Records relating to patients should not be sold. However, the sale may include, as one of its terms, unlimited access to the records of those patients who seek the services of the purchasing physician.

5. Keeping your license in force

You may wish to keep your license in force and register each year in the event that you wish to do some consultation work or are called upon to perform some act of medical practice in an emergency. If you elect to keep your license in force, you will be required to continue to meet the continuing medical education requirements. This requirement calls for 30 hours of Category I credit as defined in the Physician's Recognition Award of the American Medical Association, to be accumulated every two years. The Medical Examining Board requires this regardless of extent or nature of practice; there are no exceptions due to age or retirement.

6. Malpractice insurance

Your policy should be examined to determine whether it is written on a CLAIMS INCURRED or a CLAIMS MADE basis. Consult your insurance agent. If the policy is written on a CLAIMS MADE basis, only those claims made while the policy is in force will be covered and you should either continue your coverage or purchase coverage extension to protect you until all statutes of limitation have run.

7. Accounts receivable

Not all of your patients will have paid their bills by the time your practice is closed. It will be necessary to have someone available to accept, record, and deposit payments received after the official closing of your practice. You may wish, after a suitable waiting period of three or four months, to turn those accounts still unpaid over to a reputable collection agency.

8. Continuation of SMS membership

We hope that you will continue to be active in the Society. This can be done by notifying your County Society, in writing, that you are closing your practice but wish to remain active in Society affairs. The County Society will notify you of its dues, if any, for inactive physicians. There are no dues for continuation of SMS or AMA membership in such cases.

9. Income taxes

Copies of your income tax returns and all supporting documentation, including ledgers and accounting records, should be preserved until the Internal Revenue Service can no longer assess additional tax. For returns filed on time and containing all correct and pertinent data, this is usually three years; for returns where gross income has been understated by 20 percent or more, it is six years; for fraudulent returns or where no return has been filed there is no time limit.

10. Payroll taxes

Final returns and payments of all Federal and state withholding and Social Security taxes must be made after the last employee has been terminated and the last payroll paid.

Finally, it is recommended that you work closely with your attorney or business manager particularly on the tax aspects of closing your practice. ■

MEDIC ALERT
FOUNDATION INTERNATIONAL

The Medic Alert emblem is designed to alert emergency personnel to hidden medical conditions. On the back of the emblem is the member's hidden medical condition along with an ID number and 24-hour emergency telephone number which can be utilized to retrieve the computerized emergency medical data within seconds.

Information that is stored can include physician's telephone number, type of insurance policy, next-of-kin, blood type, medication name and dosage.

The Medic Alert Foundation estimated that one out of five Americans has a hidden medical condition, ranging from serious medication allergies to heart problems and diabetes.

In a recent twelve-month period, the service which is subscribed to by over 1.3 million people was directly credited with saving over 2,000 lives.

Free information can be obtained from Medic Alert, Turlock, California 95380. ■

Problems of a Physician's Widow/er

FOLLOWING THE LOSS of one of its members by death, it has long been the practice of the State Medical Society to write the physician's widow/er in an effort to provide some advice during a trying period. The Society, believing that "an ounce of protection is worth a pound of cure," suggests that every member give thoughtful consideration to some of the problems which are likely to face a physician's widow/er. Careful preparation for such eventualities not only protects the family, but eases its burdens at a trying time.

Following the death of a physician, the widow/er will be faced with many decisions involving the settlement of the business affairs relating to the late husband's or wife's practice. It is of extreme importance that she/he act upon the advice of an attorney. When practical it is recommended that the physician acquaint his/her spouse with his/her legal and other advisors and some of his/her business affairs. This will provide an established working business relationship between the spouse and the advisors for that eventuality when she/he is called upon to act. Some of the chief problem areas the widow/er will face are outlined in the remainder of this article.

Former patients may seek a continuation of medication prescribed by the deceased physician. This must never be permitted except on advice of another physician because of the possibility of rapid change in the condition of the patient and resultant possible cause for legal action in the event unexpected results stemmed from continued use of the medication.

The widow/er also will be presented with the problem of what to do with the physician's narcotics. The Regional Administrator of the Drug Enforcement Administration, Chicago, Illinois, has jurisdiction over the State of Wisconsin with regard to disposal of unused controlled substances. The following procedure has been approved as a guide to physicians:

"The physician's DEA number (Controlled Substances Registration Certificate), unused Government order forms and controlled drugs should be disposed of as soon as possible. The registration certificate and unused Government order forms (DEA-222 c) should be returned to the Drug Enforcement Administration, Registration Branch, P.O. Box 28083, Central Station, Washington, DC 20005. The controlled drugs may be disposed of by shipment, charges prepaid (shipment by registered mail is permissible) to the Regional Administrator, Drug Enforcement Administration, 219 South Dearborn, Suite 1800, Chicago, Illinois 60604, after the drugs have been inventoried on Form DEA-41, which can be obtained from any DEA office. One copy of the Form-41 will be returned to the sender upon receipt of the narcotic drugs. No remuneration will be made for the narcotics surrendered to DEA."

Forms and additional information may be obtained from the Milwaukee District Office: Drug Enforcement Administration, 517 East Wisconsin Ave., Room 228A, Milwaukee, Wisconsin 53202; (414) 224-3395.

It is important that a widow/er, other members of the family, and the attorney see to it that there is full and prompt compliance with the requirements of the above communication.

Instructions on the disposal of non-narcotic drugs in the possession of the physician at the time of his/her death may be obtained from the Wisconsin Pharmacy Examining Board, 1400 E Washington Ave, Madison, Wis 53702.

Records relating to patients, including case histories, treatment records, x-rays, laboratory reports, correspondence with physicians and others should not be destroyed for at least six years after the physician's death. Liability for malpractice and some other claims do not cease upon the death of a physician.

The physician's records and liability insurance policies may be the widow/er's chief sources of defense. Every precaution should be taken to insure that all such basic materials are kept intact and subject to immediate call for at least six years. The family attorney will be able to tell when they are no longer needed for this purpose.

The widow/er can expect that the deceased physician's patient will seek care elsewhere unless he/she had one or more associates. Sometimes the new physician will find it necessary for adequate treatment to obtain a copy of the previous physician's record of care of his/her patient. In such event, it is wise to insist upon a written request from the patient and his/her new physician. A copy of the record, with a covering letter may then be sent. A copy of the forwarding letter should be inserted in the original patient's file for future reference.

A decision may be made to sell the deceased physician's practice. The items to be included in the sale will vary with the nature of the practice, the amount of equipment involved and the wishes of the buyer.

To avoid complications, the widow/er should make sure the buyer is a physician licensed in Wisconsin. This information can be obtained from physician acquaintances or the State Medical Society. Records relating to patients should not be sold. However, the sale may include, as one of its terms, unlimited access to the records of those patients who seek the services of the purchasing physician. The widow/er's legal and other advisors can best inform her/him how to arrange the sale.

The collection of the deceased physician's professional accounts is another important matter. The widow/er should carefully follow her/his attorney's advice before bringing suit, since a patient can

counterclaim for malpractice within three years. Ordinarily it is not desirable for a widow/er or the heirs to enforce collection by suit within such period. She/he should also seek legal and accounting advice on how long to retain the financial records of her/his late spouse. It is quite possible that his/her estate may be subjected to audit by the state or federal income tax authorities. The retention of complete records is essential in anticipating such possibility.

A widow/er should consult her/his attorney as to whether the estate needs to arrange a malpractice policy buy-out with the deceased physician's carrier so as to protect the estate assets and the widow/er's share of such assets. Some physicians will have attempted to do this during lifetime and if they did so this will be evident from study of the policy, its endorsements and correspondence. If there is uncertainty in the matter, the attorney should contact the insurance carrier and seek its cooperation in ascertaining the facts. The reason for this is that a suit can be maintained against the estate and heirs of a deceased physician who is alleged to have committed one or more acts of professional negligence with resultant injury to a patient.

The State Medical Society office is always available for consultation with a widow/er, the family, or the estate attorney. ■

"WATS" LINE FOR MEMBERS

The in-WATS (toll-free) line can be used to contact anyone at SMS headquarters (330 East Lakeside Street, Madison) from anywhere within the State of Wisconsin between the hours of 8:00 am and 4:30 pm weekdays. The number to dial is:

1-800-362-9080

24 HOUR

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Green Bay—414/494-3675
Madison—608/249-6604

Package Boiler Burner Service Corp.
5401 N Park Dr-PO Box 365-Butler, WI 53007
Phone: 414/781-9620

How to get health-related information in Wisconsin

THE WISCONSIN HEALTH Sciences Library Network, a network of libraries that blanket the state, stands ready to put Wisconsin health-care practitioners in touch with information in libraries throughout the country.

Any practitioner needing such information should first contact the library in his or her institution. If the person is an independent practitioner or the institution has no library, another local hospital or clinic should be contacted. Many such libraries will now serve people who are not among their primary clientele. A great number of these libraries are now organized into resource-sharing consortia and can get a needed item quickly even if they do not have it in their own collection. The libraries are also eligible to forward requests to the two Wisconsin resource libraries—in Madison (the UW Middleton Health Sciences Library) and in Milwaukee the Todd Wehr Library (Medical College of Wisconsin). The local libraries are likely to have the tools to identify which other library has the needed information.

If no local library can be found to provide these services, inquiries can be sent directly to the resource libraries at the addresses given below. Any requests that can't be filled at the state level are eligible for referral to resource libraries in the Midwest Health Science Library Network, which encompasses a six-state area and to the National Library of Medicine.

In addition to providing lending and photocopying services, the two resource libraries and many of the local libraries provide reference service. Computer searches, including MEDLINE, can now be done at the resource libraries and at Columbia, St Joseph's, St Luke's St Mary's, St Michael's, Mt Sinai, St Francis hospitals and Good Samaritan Medical Center, Lutheran Campus in Milwaukee; Milwaukee County Medical Complex; Trinity Memorial Hospital, Cudahy; VA Hospital, Wood; St Elizabeth's Hospital, Appleton; Luther Hospital, Eau Claire; La Crosse Lutheran Hospital, La Crosse; Marshfield Clinic, Marshfield; Bellin Memorial Hospital, Green Bay; Waukesha Memorial Hospital, Waukesha; the Howard Young Medical Center, Woodruff; Holy Family Hospital, Manitowoc; Theda Clark Regional Medical Center, Neenah; Mercy Medical Center, Oshkosh; Methodist and Madison General hospitals, St Mary's Hospital Medical Center, VA Hospital, and UW Clinical Sciences Center in Madison. If your local library cannot provide computer searches, it can forward any request to the most appropriate library in the network.

In most cases, the only charges will be for computer searches and for photocopies.

University of Wisconsin
Middleton Health Sciences Library
1305 Linden Drive
Madison, Wisconsin 53706
800-362-3020
Ext 2-2376

Medical College of Wisconsin
Todd Wehr Library
Box 26509
Milwaukee, Wisconsin 53226
414/257-8326 ■

Uniform Anatomical Gift Act

WISCONSIN, along with some 40 other states, has adopted the Uniform Anatomical Gift Act, a law under which a donor may leave all or any part of his/her body for research or transplantation. With the continuing publicity given to transplant technology, physicians are being queried about the law and how their patients may make anatomical gifts.

To assist physicians in providing the necessary information to patients, the University of Wisconsin-Madison Anatomy Department and the Medical College of Wisconsin Department of Anatomy have provided the State Medical Society with policy statements in the acceptance of bodies. These statements appeared in the June 1981 BLUE BOOK, on pages 46-47. Further information may be obtained by contacting the Medical College of Wisconsin, Department of Anatomy, 8701 Watertown Plank Road, Wauwatosa, Wis 53226 (mailing address: PO Box 26509, Milwaukee, Wis 53226; or phone 414/257-8261); or University of Wisconsin-Madison, Anatomy Department, Bardeen Medical Laboratories, 1300 University Ave, Rm 1420 MSC, Madison, Wis 53706 (phone: 608/262-2888).

* * *

Uniform Organ Donor Cards and Decals. These are available from the National Kidney Foundation of Wisconsin, Inc, 6701 Seybold Rd, Madison, Wis 53719 (phone 608/274-0441), or 7332 West State St, Wauwatosa, Wis 53213 (phone 414/453-2830).

Donation of eyes. Inquiries may be directed to the Milwaukee Eye Bank, 8700 West Wisconsin Ave, Milwaukee, Wis 53226 (phone 414/257-5543), or to The Eye Bank, E5/410 Clinical Science Center, University of Wisconsin-Madison, Center for Health Sciences, 600 Highland Ave, Madison, Wis 53792 (phone 608/263-6223).■

The Optometrist Referral Law

SEVERAL PUBLICLY and privately sponsored glaucoma screening programs have inquired of the State Medical Society as to whether it is appropriate to refer persons suspected of elevated intra-ocular pressure directly to an appropriate medical specialist for further evaluation.

The question arises because one section of the Wisconsin Statutes, 449.01 (3), requires any agency of the state, county, municipality, or school district to give the recipient of a vision screening program equal opportunity to choose between optometric or physician services for follow-up as a consequence of vision screening activities.

At the same time, another section of the statutes, 449.19, which was passed at a later date by the Legislature, requires that an optometrist who determines the possibility of the existence of a pathologic condition to refer the person examined to an "appropriate medical specialist" for further evaluation.

The State Medical Society believes that the implication of these statutes, when taken in combination, is clearly a legislative intent that whenever there is the possibility of the existence of a pathologic condition, the patient should be referred to an appropriate medical specialist for further evaluation. The Legislature's action was a recognition of the seriousness of possible pathology in the eye and the urgency and importance of referral to medical care. The Medical Society therefore feels it appropriate that a public health nurse or other person who as a result of screening tests believes there is reason to suspect glaucoma should immediately refer directly to an ophthalmologist or other appropriate medical specialist.

At the same time, the Medical Society wishes to emphasize that the policy of nondiscrimination for referral to optometrists or physicians following tests for visual acuity must be respected and is encouraged.■

STATE DEPARTMENT OF REGULATION & LICENSING

Physician licensure

Verification

FOR SOME YEARS a number of hospitals and clinics have asked the Department of Regulation & Licensing to verify their entire list of medical staff members on an annual basis. This was a service performed by the Medical Board staff at a time when the number of Wisconsin licensees was considerably less than the current 13,000 (physicians, physical therapists, osteopaths, physician's assistants, and podiatrists). In February 1981 the Department announced that it could no longer provide this service to that extent.

The Department offers several avenues available to verify the licensure of medical professionals.

A. Purchase of the Department's current master printout of licensees (name, address, and license number) at a cost of about $60 for all licensees of the Medical Examining Board. Contact the Department's Renewal Section at (608) 266-0627 for further information and ordering.

B. Purchase of the Department's directory of Medical Board licensees which is current up to October 1980, contains no license numbers, and costs $5.20.

C. Checking, at the physician's facility, the current registration card of all Medical Board licensees. That certificate, stamped "valid to December 1981," is the physician's proof of good standing with the Medical Examining Board.

D. Writing or calling the Medical Board office when the following is true:
   1. Applicant for staff privileges is not listed in the printout or directory.
   2. Applicant for staff privileges does not produce a current registration card.
   3. Applicant is a new licensee in Wisconsin.
   4. A person has good reason to believe the Medical Examining Board has disciplined the licensee and verification of that fact is desired.

Physicians who have been members of a hospital or clinic medical staff for a number of years will be expected to show their license "renewal card" every two years to the staff.

A physician experiencing no problems on a medical staff, having a current renewal card, and not listed in the *Digest of Rules and Discipline* will not show up as a problem on the Department's records.

The Department of Regulation & Licensing and the Medical Examining Board have told the State Medical Society that they wish to assure effective regulation of the profession to the citizens of Wisconsin and, therefore, are most anxious to assist physicians in the verification process.

Reportable loss of hospital privilege

A recently enacted state law requires hospitals to report to the Medical Examining Board peer investigation information which results in a physician's hospital staff privileges being lost or reduced for 30 days or more, or which results in a physician resigning from the hospital staff for 30 days or more.

Chapter 135, Laws of 1981, which became effective March 31, 1982, requires hospitals to notify the Medical Examining Board within 30 days after the loss, reduction, or resignation takes effect. Temporary suspensions due to incomplete records need not be reported.

Within 30 days after receiving a hospital report, the Medical Examining Board must notify the physician, in writing, of the substance of the report. The physician and the physician's authorized representative may examine the report and may place into the record a statement, of reasonable length, of the physician's view of the correctness or relevance of any information in the report. An action may be instituted in circuit court to amend or expunge any part of the hospital report.

If the Medical Examining Board determines a hospital report is without merit or that the physician has sufficiently improved his conduct or competence, the Board must remove the hospital report from the physician's record.

If no hospital reports are filed against a physician for two consecutive years, the physician may petition the Board to remove any prior reports, unless those reports are related to a finding of unprofessional conduct against the physician.

Hospitals may request information relating to a physician's loss, reduction, or resignation of staff privileges from other hospitals prior to admitting the physician to the medical staff.

Introduced at the request of the State Medical Examining Board as Senate Bill 68, the law is intended to prevent the migration of physicians who lose attending privileges at one hospital and to shortly thereafter receive approval for attending privileges at another, unsuspecting hospital.

The system requires the Medical Examining Board to act as a clearinghouse for the accumulation and dispersal of disciplinary actions taken by hospitals against physicians. ■

NOTICE

Wisconsin hospital emergency rooms and outpatient facilities are aware of the following federal and state laws which prohibit . . .

I. Discrimination against patients

Alcohol abusers, alcoholics and drug abusers who are suffering from medical conditions shall not be discriminated against in admission or treatment, solely because of their alcohol abuse, alcoholism or drug abuse by any private or public general hospital or outpatient facility [as defined in section 1633 (6) of the Public Health Service Act] which receives support in whole or in part by funds appropriated to any federal department or agency. Such regulations shall include procedures for determining if a violation of subsection (a) has occurred, notification of failure to comply with such subsection, and opportunity for a violator to comply with such subsection.

U.S.P.L. 91-616, Part C, Section 321 A & B and subsequent amendments

U.S.P.L. 92-255, Section 407 A & B and subsequent amendments

II. Refusal of admission

"A private or public general hospital may not refuse admission or treatment to a person in need of medical services solely because that person is an 'alcoholic,' 'incapacitated by alcohol,' 'or is an intoxicated person' as defined in subsection (2). This paragraph does not require a hospital to admit or treat the person if the hospital does not ordinarily provide the services required by the person. A private or public general hospital which violates this paragraph shall forfeit no more than $500."

Wis. Stats. 51.45 (15) (c)

PLEASE NOTE: Hospitals not equipped to admit or provide treatment to the person must have a written plan and agreement with the nearest hospital that provides services required by the person.

Any violation should be reported to the Bureau of Alcohol and Other Drug Abuse, 1 West Wilson Street, Room 434, Madison, Wisconsin 53702. Phone 608/266-2717.

Statewide Impaired Physician Program

THE STATE MEDICAL SOCIETY Impaired Physician Program became a reality by action of the Board of Directors in June 1977. It was then, and continues to be, a function of the Commission on Mediation and Peer Review. Commission members and other physicians in the state who are experienced in identification, intervention and treatment of impaired physicians are called upon for their services. A written protocol guides the general handling of each inquiry or actually identified impaired physician.

Available to members and nonmembers alike, the program involves education, identification, assessment and compassionate intervention. It refers to treatment facilities and follows up after initial treatment has been conducted.

Since its inception, the Impaired Physician Program has achieved some success. A number of physicians afflicted with some form of impairment left their practices to enter structured rehabilitation programs through encouragement by compassionate volunteer colleagues. However, the Society recognizes that these few successes far from meet the need for rehabilitation of many other physicians continuing a lonely losing battle against alcohol or other chemicals, or who suffer from emotional illnesses, physical impairment or senility.

The experience of organized impaired physician programs in Wisconsin and elsewhere provides convincing evidence that physician impairment is substantial, but that its degree is unknown beyond what is identified and intervened. Essentially, most of the literature on this subject contends that from 10-14 percent of practicing physicians have difficulty with alcohol and drugs. Some research suggests that one out of every ten physicians during a lifetime will abuse alcohol in professional circumstances so as to be identified as "impaired."

Unfortunately at present many people in a position to observe and identify impaired physicians do not know what to do when they perceive this specific problem. The availability of help offered by organized programs is not widely known or understood. Furthermore, those individuals, such as medical staff members, hospital administrators, and others are reluctant to report a physician to an organized program, their initial reaction being not to get involved or to conclude that the problem can be handled otherwise. This attitude often results in delayed intervention and treatment or in passive action which ultimately fails.

Another present concern is that persons who otherwise might report an impaired physician, may seek legal advice, only to be told by their lawyers to be noncommittal and to respond only to a subpoena. Such advice could be a deterrent to early intervention.

Current techniques of identification, intervention, assessment, treatment, and follow-up of impaired physicians are not well known or widely known in the medical community. Furthermore, physicians are not generally adequately trained or skilled in identification, diagnosis and treatment of patients with chemical dependency. The result is that few are able to respond adequately when they accept an impaired physician as a patient.

At this time resources for treatment and appropriate follow-up of impaired physicians in Wisconsin need to be identified and publicized in greater detail. A more adequately structured system of outreach, treatment and re-entry to medical practice should be designed, made available and publicized. It should be recognized that a physician recovering from an impairment may very well bear associated financial stress, and may be unable to sustain himself and his family without insurance, grants, loans, or other types of benevolent assistance. Monitoring the degree to which the impaired physician is responding to treatment and rehabilitation and return to medical practice should be improved.

Since an impaired physician is a medical family concern involving close cooperation of the Medical Society and its Auxiliary, the Auxiliary's role in identification of impairment and providing support for spouses and families should be strengthened.

Stresses of physician education may produce chemical instability or emotional dependency. Therefore, efforts should be made within premedical, medical and residency training programs to provide resources for students and residents to deal with impairment.

The above identified concerns have been recognized by the State Medical Society since the inception of its Impaired Physician Program and that ultimately a greater funding committment would be necessary to realize an expanded and better coordinated statewide program of education, intervention, treatment and follow-up for physicians suffering impairment.

In March 1982, in response to this need, State Medical Society Board of Directors approved development of an expanded Statewide Program for Impaired Physicians to be a considerable improvement over the program which has existed for over four years. The new program contains the following elements:

Phase I: Education and Prevention

Target individuals and groups will be educated to an understanding of impairment among physicians as a result of alcohol and other drug dependency. They will be informed of the symptoms of impairment; the needs for, and techniques of early identification and intervention; the process of, and resources available for identification, assessment, intervention and treatment; ideas for prevention; and social, financial, legal and other problems associated with impairment and its treatment.

A. Primary target groups to be reached in education and prevention efforts will be:

1. Physicians: Meetings of hospital medical staffs, county medical societies, regional or statewide continuing medical education, and accredited seminars such as at the SMS Annual Meeting or special societies will be established.
2. Hospital Personnel: Hospital administrators and medical directors, chiefs of medical staffs, hospital boards of trustees, directors of nursing and pharmacy, and others such as anesthetists and technicians will benefit from educational presentations.
3. Pharmacists, Nurses and Nursing Home Administrators: Lectures will be given either through regularly scheduled meetings or their associations, or in combination with physicians and hospital personnel meetings.
4. Spouses and Families of Physicians: Educational material directed to these persons will be available at state and county medical society and auxiliary meetings.
5. Legal Profession: Efforts should be made to convince attorneys, whose state association has its own impaired lawyers program, to encourage their physician clients to utilize organized medicine's voluntary impaired physician programs when they are perceived to need such services.

B. Teaching Staff for Educational and Prevention Phase

Teaching staff will be recruited to present education and prevention information to the target groups. It is anticipated that the team approach would be used; that is, a "lead" physician plus a recovering alcoholic or drug dependent physician.

C. Teaching Resource Aids

Literature is being developed to assist understanding of alcohol and other drug dependency, and techniques and resources for intervention, treatment and follow-up. This material will provide introduction to the disease of alcoholism and other drug dependency; the function and use of the Impaired Physician Program; and family, social, financial, and legal aspects of impairment, treatment and recovery. Video tape presentations or slide cassette programs may be developed for general and specific purposes.

Phase II: Intervention and Treatment

Use of proper techniques in approaching or "confronting" impaired physicians to enter rehabilitation is crucial to success of the Statewide Impaired Physician Program. Initially, at least 20 intervenors are to be recruited and trained in strategic areas in Wisconsin to intervene with colleagues identified as impaired. These intervenors, all volunteers, will attend at least one training seminar on identification, intervention, treatment resources and follow-up. Each new volunteer will acquire experience in actual intervention by working as an assistant to an already experienced intervenor. Preferably, two intervenors are present at any confrontation.

Guidelines or aids to successful intervention or treatment are being developed concerning identification of impaired physicians, encouraging them into treatment, and providing them free choice of high quality treatment facilities and services. Criteria are being developed to guide the long-term recovery aspects of impaired physicians. Such criteria are a critical phase in the life of the recovering alcoholic or drug-dependent physician.

* * *

The Statewide Program for Impaired Physicians is under the overall policy direction of the Society's Commission on Mediation and Peer Review. However, responsibility for development, planning and operation of the program rests with a Managing Committee which is composed of representatives of the State Medical Society, DePaul Rehabilitation Hospital, and Milwaukee Psychiatric Hospital. Other impaired physician resources may be considered for a Managing Committee role if they wish to participate with both advisory and financial committment. The Managing Committee implements program development and operation with staff assistance provided by each participating organization or facility. However, the primary responsibility for staff direction continues to rest with the State Medical Society.

The State Medical Society program maintains formal linkage to the Wisconsin Medical Examining Board through the Coordinating Council on Physician Impairment, consisting of three physicians representing the State Medical Society and three members of the Medical Examining Board. The Council establishes guidelines for the Statewide Impaired Physician Program, coordinates activities so that appropriate information is shared and action taken by the Examining Board in the event of physician failure to respond to treatment and rehabilitation. It initiates and promotes educational programs on impairment and assists in providing direc-

tion for the Impaired Physician Program and the Managing Committee. Under the new statewide program this relationship continues unchanged.

Any responsible person can inform the Impaired Physician Program of a concern by calling the State Medical Society: (608)257-6781 in Madison or 1-800-362-9080 in Wisconsin. An individual reporting suspected impairments or who inquires into the program procedures is assured of strict confidentiality of all information provided. Staff assigned to receive this information will consult with the Managing Committee Chairman for early action on the case. Before action is taken, however, the information is evaluated for accuracy. When a determination is made that a potential problem exists, a confronter or intervenor team is selected to meet with the involved physician. From that point the process evolves which hopefully will assist the physician to recognize the impairment and accept the treatment plan leading to the recovery phase that returns the physician to a successful practice. ■

STATE MEDICAL SOCIETY

Mediation and Peer Review Services

PHYSICIANS ARE QUITE aware that medical care is a very personal matter between them and their patients. Medicine is not an exact science, and since each patient is different from all others and treatment approaches vary greatly from patient to patient, it is understandable that physicians and patients sometimes may not agree on what is proper care. At times misunderstandings arise about what the physician hopes to accomplish and what the patient expects. When this occurs, it is important that the patient first discuss any questions and concerns regarding medical treatment with his or her physician. In the event that such differences are not resolved at the doctor-patient level, the State Medical Society provides a means for resolving these differences.

The State Medical Society Commission on Mediation and Peer Review has the responsibility to receive, investigate, and resolve differences between physicians and patients or other complainants, and if necessary to take disciplinary action. The prime standard of judgment used by the Commission is what is good medical care. Many complaints and questions are accepted by State Medical Society staff and resolved by telephone. However, only a written complaint will be considered by the Commission through its protocol. If all affected parties reside within the boundaries of a single county medical society, that society will be asked whether it wishes to assume jurisdiction of the complaint. If it does, the complaint will be transferred to the county medical society for investigation and resolution.

A Protocol Manual was developed by the Commission on Mediation and Peer Review and approved by the Society's Board of Directors for conducting resolution of patient complaints, employing peer review mechanisms to test practice patterns of physicians, and responding to impaired physician inquiries or requests for action. It is reproduced below.

While reviewing this Protocol Manual, consider that it was designed to accomodate informal disposition of minor and uncomplicated complaints as well as complex and serious matters which raise questions including due process, patient or physician appeals, proposed disciplinary actions, and Board of Directors consideration of continuation of a physician's State Medical Society membership. Certain complaints received by the Commission on Mediation and Peer Review are resolved through case evaluation by a subcommittee of the Commission whose members provide reports and recommendations to the Chairman regarding the complaints. Frequently this subgroup reaches conclusions which are imparted in writing to both the subject physician and, as appropriate, to the complainant. In any event, all cases are reported to the Commission. Matters of more serious nature require application of the Protocol Manual as necessary.

* * *

COMMISSION ON MEDIATION AND PEER REVIEW

Protocol Manual

I. INTRODUCTION

Purpose

This Manual has been developed to guide and regulate the disciplinary activities of the State Medical Society of Wisconsin. It is designed to assure that these activities will be conducted fairly for all parties involved and will meet relevant legal standards of due process. In conducting its activities under this Manual the Commission is organized and shall be operated for the purpose of improving the quality of health care.

Factual Background

The Commission on Mediation and Peer Review is assigned the function of investigation, evaluation and decision of disciplinary matters for the State Medical Society of Wisconsin, subject to its Constitution and Bylaws and the policy control of its House of Delegates and Board of Directors. The procedures for conducting this disciplinary activity have been delegated to the Commission. In developing these protocols the Commission has considered Society discipline in relation to its other activities including mediation, peer review, and assistance to impaired physicians.

Jurisdiction

A. The Commission has jurisdiction over all complaints from whatever source on the basis of which any form of discipline may be imposed by the Society.
   1. If the substance of a complaint under the jurisdiction of the Commission is also pending before any court, the Medical Examining Board or any other governmental agency, the Commission will suspend its disciplinary proceedings until the matter is resolved in the other form.
   2. The Chairman of the Commission may, in his discretion and with the concurrence of the county medical society involved, cede jurisdiction over any disciplinary matter to a county medical society.
   3. The Chairman of the Commission may, in his discretion, accept jurisdiction over any disciplinary matter initiated before a county medical society if requested to do so by any party to the proceeding and if the county medical society involved concurs.
   4. The Society, through the Commission, may exercise original jurisdiction over complaints made to the Society.

B. The Commission has jurisdiction over all requests for peer evaluation of physicians and their services.

C. The Commission has jurisdiction over Society efforts to assist and rehabilitate impaired physicians.

D. In exercising its jurisdiction under these protocols the Commission shall follow, interpret and implement the policies of the State Medical Society of Wisconsin.

Commission Organization

A. For purposes of conducting its activities under this Manual, the Commission shall be organized to perform the following functions: (1) receipt and screening of complaints and requests, (2) mediation/investigation, (3) confrontation of impaired physicians, (4) case coordination, and (5) fair hearing.

B. The Chairman of the Commission may assign members of the Commission to the various functions, which assignments may be made on a term or case-by-case basis.

C. The Assignment of members of the Commission shall be made in a manner to assure that: (1) physicians who are subject to actions under the Commission's jurisdiction are treated fairly and decisions affecting them are made in an unbiased manner; (2) the Commission operates efficiently for the purposes for which it was created; and (3) the abilities and interests of Commission members are used effectively.

II. MEDIATION PROCEDURES

Complaints

A. All complaints on the basis of which discipline may be imposed by the Society shall be directed to the Chairman of the Commission or his designee for initial screening and acknowledgement.
   1. Initial screening involves determination whether the complaint is one upon which disciplinary action may be taken and whether it is in a form to be acted upon by the Commission. At this stage complaints and inquiries which may lead to complaints may be informally handled and, if possible, resolved without further proceedings.
   2. All complaints shall, if possible, be acknowledged indicating (a) whether the complaint is one upon which disciplinary action may be taken, (b), whether it is in form to be acted upon by the Commission, and (c) if not, what the complainant must do to put it in proper form. If the complaint is one upon which disciplinary action may be taken, a copy or abridgement of the relevant portions of the Society's Constitution, Bylaws and these protocols shall accompany the acknowledgement.

B. To be in form to be acted upon by the Commission, a complaint must:
   1. Be in writing;
   2. Be signed by the complainant;
   3. Identify the complainant and the physician complained against by name and address;
   4. State the nature and reasonable details of the complaint and identify, to the extent complainant is able to do so, other sources of information bearing on the complaint.
   5. Include an authorization permitting the Commission or its designee to inspect and copy all medical and hospital records of complainant related to the subject of the complaint and waiving all privilege and confidentiality relating to such records and to any testimony or other statements related to the subject of the complaint.

C. After screening of a complaint, if it is one upon which disciplinary action may be taken and it is submitted in proper form to be acted upon, it shall be referred by the Chairman or his designee to one or more members of the Commission for mediation and investigation.

Mediation/Investigation

A. Those members of the Commission to whom the complaint is referred for mediation and investigation (the reviewers) shall review the complaint and any other Commission records related to the subject physician.

B. The reviewers or their agents shall contact the subject physician, notifying the subject physician of the fact that a complaint has been filed and providing such detail of the complaint as they deem appropriate. They shall also provide the subject physician with a copy of these protocols.

C. The reviewers shall arrange one or more meetings, as they deem necessary or advisable, with the subject physician.
   1. The reviewers shall look into the details of the incidents upon which the complaint is based and determine the subject physician's position on these incidents.
   2. The reviewers may expand their fact finding into other parts of the subject physician's practice than those related to the complaint. The subject physician shall be responsible to obtain all necessary authorizations for the reviewers to review such records as they may request and all necessary waivers for their use of the information obtained for the functions of the Commission.
   3. As a condition to the mediation efforts of the reviewers and as an aspect of full cooperation by the subject physician, the subject physician shall

execute a written consent to mediation acknowledging that the reviewers are acting in good faith to help improve the quality of health care and waiving any right of action existing or later arising against the Society or anyone acting through it or on its behalf for good faith efforts to pursue the procedures established under these protocols.

4. In conducting their mediation efforts the reviewers may use or cooperate with other commissions or committees of the Society, county medical societies, the American Medical Association or any other public or private organization with the purpose of improving the quality of health care.

D. If it appears possible to resolve the issues of the complaint amicably between the complainant and the subject physician and this appears to be in the best interests of the public and the quality of health care, the reviewers may serve as mediators to effect such resolution.

1. In the event a complaint is resolved by mediation, the reviewers will submit a mediation report of their findings and the resolution of the matter to the Chairman of the Commission or his designee and action on the complaint shall be terminated.
2. The mediation report shall be maintained on a confidential basis in the records of the Commission.

E. If the complaint is not resolved by mediation, the reviewers shall submit an investigation report and recommendation for action to the Chairman or his designee.

1. The investigation report shall contain: (a) a synopsis of the complaint, (b) a summary of the reviewers' actions to investigate the complaint, (c) a statement of any investigation by reviewers beyond the scope of the complaint, (d) the reviewers' findings on the quality of health care provided by the subject physician in regard to the matter complained of and other aspects of the practice of the subject physician together with excerpts or copies of records or other matters discovered during the investigation which affect their findings, and (e) the reviewers' recommendations.
2. The reviewers may recommend: (a) dismissal of the complaint, (b) additional mediation to resolve the complaint or to correct deficiencies in the subject physician's practice, (c) proceeding with the Complaint before the Commission, or (d) such other action as the reviewers deem appropriate.
3. The Chairman or his designee, after consideration of the report and, if he deems it advisable, meeting with the reviewers, shall accept the reviewers' recommendations and proceed on the basis of them or pursue a different course of action, in which event he shall prepare and append to the investigation report a statement of his reasons for not accepting the recommendations. A copy of this statement shall be given to the reviewers.
4. The investigation report and any statements appended to it shall be maintained on a confidential basis in the records of the Commission.
5. Further action of the Commission on the matter shall be as determined by the Chairman or his designee. If further mediation is ordered, those members assigned to conduct it shall serve and report as reviewers under these protocols.

F. Failure of the subject physician to cooperate fully with the work of the reviewers may be considered cause for the imposition of discipline under these protocols.

Hearing

A. For each complaint with which the Commission proceeds, the Chairman or his designee shall name one member of the Commission as the Commission case coordinator.

1. The Commission case coordinator shall review the investigation report and recommendation and all other matters related to the complaint and investigation and may contact the complainant, the reviewers, the subject physician or such other persons as he deems necessary to prepare and present a case to a hearing panel. The Commission case coordinator may request from the Chairman such assistance as he may require for this purpose.
2. The Commission case coordinator shall prepare charges and specifications against the subject physician. These charges and specifications shall state the basis upon which discipline is sought and the alleged actions of the subject physician which may justify disciplinary action.
3. The Commission case coordinator shall be responsible for the preparation and presentation to the hearing panel of evidence, including witnesses, documents and physical evidence, relating to the imposition of discipline against the subject physician.

B. Within 15 days after advancement of a complaint for hearing, the Chairman or his designee shall appoint a hearing panel of not less than three members to hear the complaint.

1. None of the members appointed to the hearing panel shall have been involved in any way in the receipt, screening, reference, mediation or investigation of the particular complaint at any prior time nor shall any member be appointed to a hearing panel if there is any reason he would be unable to evaluate the matter fairly and objectively.
2. One of the members of the hearing panel shall be designated presiding officer of the panel by the Chairman or his designee.
3. The hearing panel shall be responsible for receipt and evaluation of evidence on the charges and specifications in each matter heard by it and for determination on the basis of the evidence received what discipline, if any, should be imposed by the Society against the subject physician.

C. The Commission case coordinator shall notify the subject physician by registered or certified mail with return receipt of the charges and specifications against him. This notice shall also include the time, date and place of the hearing on these charges and specifications as set by the presiding officer of the hearing panel. The hearing shall be set not less than 10 days nor more than 30 days after mailing of the notice, subject to rescheduling by agreement of the presiding officer, the Commission case coordinator and the subject physician.

D. The rules of procedure for a hearing under these protocols shall be:

1. The complainant and the subject physician shall have the right to be present at all times when the hearing panel is hearing testimony or receiving other evidence.
2. The complainant and the subject physician shall have the right to be represented at the hearing by a person of his choice, who may be an attorney.
3. The complainant and the subject physician shall have the right to present witnesses, documents and physical evidence relevant to the charges and specifications before the hearing panel.
4. The presiding officer may appoint a hearing officer to conduct the hearing procedure. If a hearing officer is appointed, he shall exercise the procedural discretions of the presiding officer under these protocols.
5. The hearing panel shall not be bound by rules of evidence applicable in courts of law but the presiding officer may limit evidence presented to that which is relevant and not unreasonably cumulative and may set time limits for the presentations of the Commission prosecutor and the subject physician so long as the limits set do not deprive the subject physician of a fair hearing of his case.
6. The order of hearing shall be: (a) the Commission case coordinator presenting evidence relating to the imposition of disciplinary actions; (b) the subject physician; (c) rebuttal by the Commission case coordinator. During rebuttal no new matters may be raised. Evidence may be presented by question and answer, in narrative form, or whatever manner the party chooses. There shall be no cross-examination but the hearing panel and hearing officer, if any, may ask questions of any witness. If the subject physician fails to appear at the hearing the Commission case coordinator shall present the evidence relating to the imposition of disciplinary action and this shall form the record upon which the hearing panel acts.
7. Parties may file written summaries or briefs within time limits set by the presiding officer.
8. All hearings may be recorded stenographically or electronically.
9. As to all other procedural matters the presiding officer shall establish such rules as will insure a fair and impartial hearing.

E. In those situations in which discipline is imposed for failure of the subject physician to pay dues or as a result of the subject physician's loss of his license to practice medicine, no mediation or investigation is necessary before prosecution. The Commission case coordinator shall have made a *prima facie* case by presenting a signed statement from the treasurer of the Society that the subject physician's dues are unpaid, or from a member or staff person of the Medical Examining Board that the subject physician is no longer licensed to practice medicine in Wisconsin, as appropriate.

F. The hearing panel shall meet in executive session to determine what discipline, if any, shall be imposed.
   1. Discipline may include private or public reprimand, limitation, suspension or revocation of the subject physician's membership in the Society. The hearing panel may also recommend to the Society's Board of Directors that the matter be referred to the proper governmental agency for further action. This referral may be made only by act of the Board of Directors.
   2. The hearing panel shall reduce its decision to writing stating: (a) the facts found by it, (b) that these facts do or do not support the imposition of disciplinary action, and (c) the discipline imposed or that no discipline is imposed. The decision shall be signed by a majority of the hearing panel and if any member of the hearing panel disagrees with the decision that member may present separate views which shall be appended to the decision.
   3. A copy of the decision and separate views, if any, shall be sent registered or certified mail with return receipt to the complainant and the subject physician.

G. Within 15 days after the date of mailing of the decision, either the complainant or the subject physician may request in writing addressed to the Chairman that the matter be reheard.
   1. Rehearing may be granted by the Chairman only on the grounds of material error by the hearing panel or new evidence which could not reasonably have been presented at the hearing. The request must be specific in stating and supporting the grounds asserted.
   2. The rehearing, if granted, shall be held on 15 days' written notice to all parties who appeared at the hearing. It shall be limited to those matters stated as grounds for seeking rehearing.
   3. A matter returned for rehearing shall be decided considering the additional evidence presented together with that originally presented. A decision as outlined in paragraph E., above, shall be issued and served.

H. The decision of the hearing panel shall stand as the act of the Society and shall be accepted and ratified by the Board of Directors unless it is appealed as provided in these protocols or the Board of Directors on its own motion determines the return of the matter to the Commission for further proceedings.

Appeal

A. A decision of a hearing panel may be appealed to the Board of Directors by either the complainant or the subject physician.
   1. A notice of appeal shall be filed with the Secretary of the Society in writing within 15 days after (a) the final decision or (b) notice of denial of a request for rehearing is mailed to the party taking the appeal.
   2. The notice of appeal must state: (a) the basis upon which it is taken, (b) that part or parts of the decision with which the appealing party disagrees, and (c) the appealing party's proposed modification of the decision.

B. An appeal under these protocols shall be set as a special order of business on the agenda of the Board of Directors not sooner than 15 days nor later than 90 days after the notice of appeal is filed with the Secretary unless all parties agree otherwise.
   1. A summary of the matter shall be prepared by the presiding officer of the hearing panel for distribu-

tion as a confidential enclosure to the agenda on which this item appears.

2. If the Secretary deems it necessary, all or part of the record of the hearing panel, including exhibits, documents and physical evidence, shall be made available to the directors in advance of or at the hearing of the appeal.

C. The appeal shall be heard before the Board of Directors in closed session.

1. The case for complainant shall be presented by the Commission case coordinator or his representative. The case for the subject physician shall be presented by the subject physician or his representative.
2. No new evidence may be presented on appeal nor will witnesses be heard. Presentations will be limited to argument of the issues as stated in the notice of appeal. Reference to evidence presented to the hearing panel may be made during such argument. The appealing party shall speak first and be given time for rebuttal. Written summaries or briefs may be submitted within time limits set by the Board of Directors.
3. The Chairman of the Board of Directors may set other rules of procedure, including reasonable time limitations, as he deems appropriate.

D. The Board of Directors may affirm, modify or reverse the decision appealed from or may refer the matter for further hearing and decision to a hearing panel with whatever instructions it deems appropriate.

E. The Board of Directors shall hear and decide appeals from disciplinary decisions of county medical societies using the same procedures as those set forth herein for decision of appeals from a hearing panel.

III. PEER REVIEW PROCEDURES

Requests

A. All requests for peer evaluation of physicians and their services shall be directed to the Chairman of the Commission or his designee for initial screening and acknowledgement.

1. Initial screening involves determination whether the evaluation procedure is one which the Commission is empowered to undertake and capable of undertaking and whether the requesting party is one for which the Commission may legally undertake the requested evaluation.
2. Compensation to the Society for the Commission's peer review activities shall be set by the Board of Directors.
3. The request shall contain such authorizations for the inspection, copying and use of records as the requesting party has relating to the subject matter of the request.
4. In acknowledging the request a copy of these protocols shall be supplied to the third party unless this has been done previously.

B. After screening of a request, if it is one which the Commission is empowered to undertake and capable of undertaking and the requesting party is one for which the Commission may legally undertake the requested evaluation, it shall be referred to one or more members of the Commission for evaluation.

Evaluation

A. Those members of the Commission to whom the request is referred for evaluation (the evaluators) shall review the request and any materials sent with it.

B. The evaluators or their agents shall contact the subject physician, notifying the subject physician of the fact a request has been received and providing such detail of the request as they deem appropriate. They shall also provide the subject physician a copy of these protocols.

C. The evaluators shall make as thorough an investigation as possible of the matters relating to the request so as to be able to report responsively to the requesting party.

1. The investigation may include meeting with the subject physician if the evaluators deem this necessary or advisable.
2. The evaluators shall seek to obtain, from the subject physician or otherwise, all authorizations for the inspection, copying and use of records necessary for them to investigate the matters thoroughly.
3. The subject physician shall be asked to execute a written consent to review acknowledging that the evaluators are acting in good faith to help improve the quality of health care and waiving any right of action existing or later arising against the Society or anyone acting on its behalf for good faith efforts to pursue the procedures established under these protocols. Refusal to execute this consent and waiver may be considered cause for the imposition of disciplinary action against the subject physician.
4. In conducting their review the evaluators may use or cooperate with other commissions or committees of the Society, county medical societies, the American Medical Association or any other public or private organization with the purpose of improving the quality of health care.

Report

A. Following their investigation the evaluators shall prepare a review report and submit this to the Chairman or his designee.

1. The review report shall be responsive only to the specific request of the third party and summarize the findings of the evaluators' investigation.
2. In addition, the evaluators may submit a supplemental report to the Chairman or his designee covering matters found in their investigation not bearing on a responsive reply to the request. The Chairman or his designee may, on the basis of the supplemental report, initiate mediation procedures or recommend that the Board of Directors refer the matter to an appropriate public or private organization.
3. Except as otherwise provided herein, the review report and any supplemental report shall be maintained on a confidential basis in the records of the Commission.

B. The Chairman or his designee shall read the review report and may, upon consultation with the evaluators or others, make modifications in it.

C. Once the review report is in final form, a copy shall be sent on a confidential basis to the third party who requested the peer evaluation and a copy shall be sent to the subject physician informing him that he may submit a statement objecting to or clarifying the review report. If any such statement is received a copy shall be promptly sent to the third party.

IV. IMPAIRED PHYSICIAN PROCEDURES

Requests

A. All requests for assistance to an impaired physician or notification of need for such assistance shall be directed to the Chairman of the Commission or his designee for initial screening and acknowledgement, if appropriate.
   1. The term "impaired physician" includes physicians whose professional or personal well being or performance is adversely affected or threatened by abuse of alcohol or other chemical substances, or by reason of physical or mental illness or senility.
   2. Initial screening involves verification of the facts underlying the request for assistance or notification.

B. After screening, if the situation involves an impaired physician, the Chairman shall designate a member of the Commission (the confronter) to "confront" the impaired physician in the company of a consultant. The consultant should be chosen on the basis of experience in the field of the subject physician's impairment, if possible.

Confrontation

A. The impaired physician shall be confronted compassionately by the confronter and the consultant with respect to the impairment and advised of the concerns of colleagues, family and others.

B. The confronter shall discuss the impairment with the subject physician and urge acceptance of appropriate recommendations of assistance. The confronters shall not provide any form of therapy, but rather recommend available types of therapy and identify and suggest rehabilitation facilities through which therapy is available.

C. Confrontation on more than one occasion by different teams of confronters and consultant may be necessary.

D. Assuming the subject physician accepts and enters a course of rehabilitation or therapy, liaison shall be maintained with the impaired physician and seek to obtain reports concerning his progress rather than the details of therapy.

E. All records, notes and reports related to the confrontation of impaired physicians shall be maintained on a confidential basis in the records of the Commission.

Referral

A. In the event the subject physician refuses to accept confrontation, declines to enter or continue a recommended course of treatment, or abandons treatment prematurely, the Chairman of the Commission or his designee shall on consultation with the chairman of the Board of Directors refer the matter to the Medical Examining Board or other appropriate agency if the subject physician poses a potential health hazard to the public.

B. If no such potential health hazard exists, the Chairman of the Commission may recommend that the Board of Directors refer the matter. The Board of Directors shall not refer the subject physician to the Medical Examining Board until it has advised the subject physician in writing of its intent to refer, the reason for referral, and has allowed 15 days for an appeal of the proposed action. ■

Join the "Beaumont 500 Club"

The Fort Crawford Medical Museum at Prairie du Chien—a national historic landmark—is in need of special financial support to assure its preservation and to aid its restoration and expansion as a medical and public health museum. Originally restored with WPA funds in the mid-1930s, the museum is in need of major repairs and renovation as well as completion of a Medical Hall of Fame, special displays featuring medical memorabilia from Wisconsin medical families, and the expansion of audio-visual presentations in the Dessloch Theater and Stovall Hall of Health.

Physician and other support is solicited to establish the Medical Museum Endowment Fund, a permanent fund of at least $500,000, the income from which is earmarked for the operation and maintenance of the museum. Contributions of any amount are encouraged.

The first 500 physicians or others who contribute $1,000 or more to the Museum Endowment Fund will join a select group known as "The Beaumont 500." All contributors will receive a newsletter, but Beaumont 500 contributors will receive a specially designed Beaumont Medallion and an invitation to an annual medical history dinner. Those who contribute $10,000 or more will receive a first edition copy of Dr William Beaumont's famous book: *Experiments and Observations on the Gastric Juice and the Physiology of Digestion* published in 1833.

All gifts are tax-deductible. For further information contact CES Foundation, PO Box 1109, Madison 53701. ■

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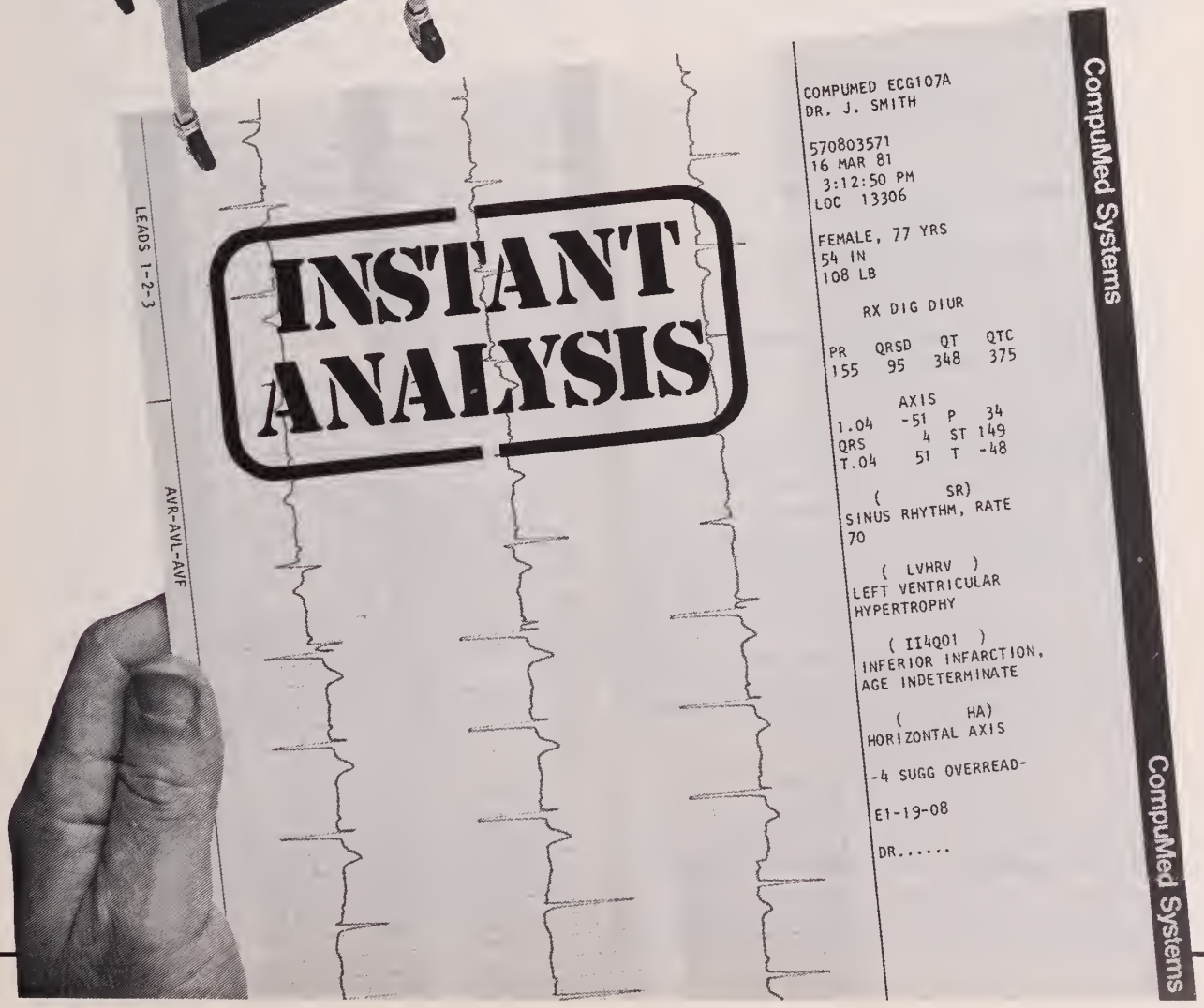

Charter Law of Medical Societies

Chapter 148

148.01 (1) State society. The state medical society of Wisconsin is continued with the general powers of a corporation. It may from time to time adopt, alter and enforce constitution, bylaws and regulations for admission and expulsion of members, election of officers, and management.

(2) A member expelled from a county medical society may appeal to the state society, whose decision shall be final.

148.02 (1) County societies. The physicians and surgeons, not less than five in number, of the several counties, except those wherein a county medical society exists may meet at such time and place at the county seat as a majority agree upon and organize a county medical society, and when so organized it shall be a body corporate by the name of the medical society of such county, shall have the general powers of a corporation, and may take by purchase or gift and hold real and personal property. County medical societies now existing are continued with the powers and privileges conferred by this chapter.

(2) Physicians and surgeons who, before April 20, 1897, received a diploma from an incorporated medical college or society of any of the United States or territories or of any foreign country, or who shall have received a license from the state board of medical examiners, shall be entitled to meet for organization or become members of the county medical society.

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(3) If there be not a sufficient number of physicians and surgeons in any county to form a medical society they may associate with those of adjoining counties, and the physicians and surgeons of not more than fifteen adjoining counties may organize a medical society under this chapter, meeting at such time and place as a majority agree upon.

(4) A county medical society may from time to time adopt, alter and enforce constitution, bylaws and regulations for the admission and expulsion of members, election of officers, and management, not inconsistent with the constitution, bylaws and regulations of the state society.

148.03 Service insurance corporations for health care. The state medical society or, in a manner approved by the state society, a county society, may establish in one or more counties of this state a service insurance corporation for health care under ch. 613.

NOTE ON ss. 148.03, 447.13, 449.15 and 450.13; Chapter 613 provides in general terms for the creation, governance and regulation of service insurance corporations for any kind of health care, as well as for other types of services. All that is needed in each authorizing chapter for professional societies is a brief section giving the appropriate professional society the power to organize a ch. 613 corporation. Section 148.03 creates that section for health care.

One basic restriction results from the repeal of the old enabling sections: none of the professional societies will be able to organize a service insurance plan within its own corporate structure. It is a mistake to permit such a mixing of professional and insurance activities within the same corporation. The society can, of course, control the service insurance corporation it creates under ch. 613, but the service insurance corporation will be legally separate. This will lead to more effective (and appropriate) control by the insurance commissioner, who should neither be empowered nor compelled, as arguably he was under the old statutes, to have any concern about the purely professional activities of the societies, because of the impossibility of disentangling the insurance and professional activities carried on by a single corporation. ■

1841—The Society created by territorial legislation

The first statutory recognition of the State Medical Society was by act of the Legislative Assembly of the Territory of Wisconsin, in Act 53 of the Territorial Legislature of 1841. The organization of the Society was authorized, with the declaration that ". . . well regulated medical societies have been found to contribute to the advancement and diffusion of true science, and particularly of the healing art . . ."

The organization meeting was set for the second Monday in January, 1842, at Madison, for the purpose of forming ". . . a society under the name and style of the Medical Society of the Territory of Wisconsin . . ." Drs. Bushnell B. Cary, M.C. Darling, Lucius L. Barber, Oliver E. Strong, Edward McSherry, E.W. Wolcott, J.C. Mills, David Walker, Horace White, Jonas P. Russell, David Ward, Jesse S. Hewett, B.O. Miller, and their associates, were authorized by statute to conduct the initial organization of the Society. ■

CONSTITUTION AND BYLAWS
of the State Medical Society of Wisconsin

CONSTITUTION

ARTICLE I
Name of the Association

The name and title of this organization shall be the State Medical Society of Wisconsin.

ARTICLE II
Purpose

The purpose of the Society is to bring together the physicians of the state of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws. As used in the Constitution or Bylaws, "physician" means a doctor of medicine or a doctor of osteopathy licensed in Wisconsin.

ARTICLE III
Component Societies

Component societies shall consist of those county medical societies chartered by the House of Delegates of this Society.

ARTICLE IV
Composition of the Association

This Society shall consist of members who shall be the members of and certified by the component county medical societies; and whose dues and assessments for the current year have been received by the Society secretary in accordance with the schedule provided in the Bylaws.

ARTICLE V
House of Delegates

The House of Delegates shall be the legislative body of the Society, and shall consist of:

(1) delegates elected by the component county medical societies,
(2) one delegate representing each specialty section of the Society organized under the Bylaws,
(3) a speaker,
(4) a vice speaker.

The officers of the Society enumerated in Article IX of this Constitution, directors, and past presidents of the Society shall be ex officio members, but without the right to vote, except that if they have been duly seated as delegates, they shall have the right to vote.

The speaker and vice speaker shall be elected by and from the House of Delegates for two-year terms, and shall be limited to three consecutive full terms in their respective offices. While holding these offices, they shall be members of the House at large and shall not represent any component county society or specialty section.

ARTICLE VI
Board of Directors

The Board of Directors, hereinafter referred to as "Board," shall have full authority and power of the House of Delegates between sessions of the House. It shall consist of the directors, immediate past president, president, president-elect, speaker and vice speaker of the House of Delegates. The secretary and the treasurer shall be ex officio members of the Board, but without the right to vote. A majority of its voting members shall constitute a quorum.

Directors shall be elected from eight geographic districts whose boundaries shall be determined by the House of Delegates. There shall be elected one director from each district, except that in any district with 200 or more regular and special members, there shall be elected one additional director for each additional 200 members or majority fraction thereof. As nearly as possible, one-third of the members of the Board shall be elected each year.

Each director shall be nominated and elected only by the elected delegates of the county medical society or societies from the district in which the director's principal place of practice is located. Such election shall be subject to the approval and confirmation of the House of Delegates.

The terms of the directors shall be for three years. No individual shall be permitted to serve more than three consecutive three-year terms as director, and no more than a total of six terms of service as director shall be permitted.

ARTICLE VII
Specialty Sections

The House of Delegates shall provide for a division of the Society into specialty sections.

ARTICLE VIII
Meetings

Section 1. The Society shall hold an Annual Meeting, at which time the House of Delegates shall meet to conduct its business. The Annual Meeting may also include scientific sessions as determined by the Board.

Sec. 2. The place for holding each Annual Meeting shall be fixed by the House of Delegates, or, by failure to act, such authority is delegated to the Board. The time for holding each Annual Meeting shall be approved by the Board.

Sec. 3. Special meetings of the House of Delegates shall be called by the speaker on written request of twenty delegates representing at least 10% of the component county medical societies, or on request of a majority of the Board. When a special meeting is called, the speaker shall set the time and place. The secretary shall mail a notice to the last known address of each member of the House of Delegates at least twenty days before the date of the special meeting. The notice shall specify the time and place of the meeting and the purpose for which the meeting is called. The meeting shall consider no business except that for which it is called.

ARTICLE IX
Officers

Officers of this Society shall be a president, a president-elect, a secretary, and a treasurer. The president-elect and treasurer shall be elected annually by the House of Delegates. The secretary shall be elected annually by the Board. The president-elect shall automatically succeed to the office of president at the conclusion of the term as president-elect.

Adopted by the House of Delegates March 27-28, 1981.

The treasurer shall be limited to nine consecutive terms.

No person shall hold more than one of the following offices concurrently: president, president-elect, secretary, treasurer, speaker, vice speaker, director. Incumbents shall serve until their successors are elected and installed.

ARTICLE X
Funds and Expenses

Funds may be raised by annual dues or by assessment on the members, or in any other manner approved by the House of Delegates. The House may establish regular and special classifications of membership. Dues, if any, shall be applied equitably to all members in each class.

All resolutions adopted by the House of Delegates providing for appropriations shall be referred to the Board for implementation. All expenditures approved by the Board shall be included in the annual budget.

ARTICLE XI
Referendum

The House of Delegates may, by a two-thirds vote of those registered at that session, submit any question to the membership of the Society for its vote, except amendments to the Constitution. Such amendments are governed by Article XIII. The House shall determine prior to submission whether a referendum shall be advisory or binding, and so advise the membership at the time of submission. A majority vote of all the members of the Society shall determine the question on a binding referendum.

ARTICLE XII
Seal

The Society shall have a common seal. The power to change or renew the seal shall rest with the House of Delegates.

ARTICLE XIII
Amendments

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the members of the House present at any Annual Meeting, provided that such amendment shall have been introduced in the form of a constitutional amendment in open session at the previous Annual Meeting, and that it shall have been published at least once during the year in the Journal of this Society, or sent to each member of the Society at least two months before the meeting at which final action is to be taken.

BYLAWS

CHAPTER 1
Membership

Section 1. The name of a physician on the official roster of this Society, after it has been properly reported by the secretary of the county society, shall be *prima facie* evidence of membership and of the right to benefits.

Sec. 2. No person whose name has been dropped from the roll of members of a component society or this Society shall be entitled to any of the rights or benefits of this Society, except that such rights and benefits shall continue during the period of an appeal by such person to the Board of Directors.

Sec. 3. Every physician who holds a license to practice medicine and surgery in Wisconsin shall be eligible to apply for membership. Each county society shall be the judge of the initial and continuing qualifications of its members, as well as the appropriate membership classification, subject to review and final decision by the Board of this Society. Members will conduct themselves in a manner which is not in conflict with the purposes for which the Society is organized and is operating.

Sec. 4. By provision of its constitution or bylaws, a county society may require that an applicant shall have practiced within its jurisdiction for a period of one year as a condition for election to membership; or that an applicant may first be elected to membership for a term of one year only, then resubmit to election by vote of the county society without limitations as to term.

Sec. 5. A member of a component society whose license has been revoked, suspended, nonrenewed, or voluntarily surrendered, shall be immediately and automatically suspended from membership as of the date of revocation, suspension, nonrenewal, or voluntary surrender, pending definitive action by the Board.

Sec. 6. A physician's county society membership must be held in that county in which the physician's principal practice is located. However, a physician living near a county line may hold membership in that county most convenient for attending meetings, with concurrence of the component society in which the principal place of practice is maintained.

Sec. 7. A member whose principal practice is moved from within the territorial limits of a component medical society to the territory of another component of the State Society shall not be eligible to continue membership in the first such society after the expiration of the calendar year in which such move shall have occurred. Such member shall, however, be eligible to apply for membership anew, or by transfer to the society into whose jurisdiction the principal practice has been moved. The member shall be given a written certificate of transfer for transmission to the secretary of the society in the county to which he has moved. Pending acceptance or rejection by the society in the county to which he has moved, such member shall be considered to be in good standing in the first society and in the State Society until the end of the period for which dues have been paid.

Sec. 8. When the principal practice of a member in good standing in a component society is moved outside the borders of this state, active membership in such component society and in the State Society may be continued by fulfilling all requirements of membership except residence pending acceptance as a new or transfer member by the society of the area to which the practice has been transferred. The period of such continuing membership in this state shall cease upon acceptance by a society in the new area of practice, and shall in no event continue beyond two full calendar years after that in which the practice location has been transferred.

Sec. 9. *Membership Classifications.* Members defined in this section, except Affiliates, shall have all the rights and privileges of the Society and shall pay dues and assessments, as indicated, as a requirement of continued membership.

A. *Regular.* Regular members of this Society consist of all the regular members in good standing of the component county societies.

B. *Special.* Included in this classification are the following categories of members who by virtue of their special circumstances are entitled to reduced dues or waiver thereof:

(1) *Part-time practice.* Any physician, regardless of age, who practices 1,000 hours or less during a calendar year, but does not qualify under section 9.B. (5), may upon application, recommendation by the

county medical society, and approval by this Society, be placed in this special category.

(2) *Resident.* Physicians in approved training programs as hospital residents or as research fellows who are licensed to practice medicine and surgery in Wisconsin. Such special membership category can be maintained for a maximum of five (5) consecutive years.

(3) *Temporary Military Service.* Members who are inducted into the United States Military or Public Health Service and serve in such capacity for not more than five (5) years.

(4) *Associate.* Members who suffer a disability preventing them from practicing medicine with resulting serious financial reverses which would make the payment of dues a matter of personal hardship. Such membership shall be on an annual basis, upon recommendation of the county society and approval by the Board of this Society.

(5) *Retired.* Members who have retired completely from the practice of medicine, or who practice 240 hours or less during a calendar year, upon recommendation of the county society and approval by this Society.

(6) *Life.* Those members of the State Medical Society of Wisconsin who have been members of this or other state medical societies for fifty (50) years, or are past presidents of the State Medical Society of Wisconsin. They shall receive a certificate of Life Membership.

(7) *Honorary.* Members who have been elected to a similar classification by their county society because of outstanding contributions to the medical profession, upon approval by the Board of this Society.

(8) *Over Age 70.* Members who are age 70 effective January 1 of the following year.

C. *Affiliate.* Persons who are not otherwise eligible for membership may become affiliated with this Society in one of the following categories. Their dues or assessments, as well as rights and privileges as affiliate members, shall be determined by the Board.

(1) *Candidate.* Upon application, a county medical society or this Society may confer upon any person then attending a medical school in Wisconsin or fulfilling a postgraduate obligation prior to eligibility for licensure the status of Candidate Member.

(2) *Scientific Fellow.* The Board may confer upon any person engaged in teaching one or more of the basic sciences at an accredited college or university, and not holding the degree of Doctor of Medicine or Osteopathy, the status of Scientific Fellow.

(3) *Emeritus.* Retired members who have chosen not to renew their license, at the discretion of the Board.

Sec. 10. *Dues and Assessments.* Members shall pay dues and assessments as follows:

A. *Regular members:* full dues and assessments.

B. *Physicians in part-time practice or over age 70:* one-half of regular member dues and assessments.

C. *Physicians in residency or fellowship training:* one-tenth of regular member dues and assessments.

Dues and assessments for all other categories shall be waived, except as may be determined by the Board for affiliate members.

CHAPTER II
House of Delegates

Section 1. Each component county society shall be entitled to send one delegate and one alternate to the House of Delegates for each forty regular and special members or majority fraction thereof in this Society, provided, however, that each county society shall be entitled to at least one delegate and one alternate from that county society.

For purposes of this section, the number of members as of the close of the calendar year preceding the first session of the House of Delegates at the Annual Meeting shall determine the number of delegates to which a county society shall be entitled.

The secretary of each county society will send a list of such delegates and alternates to the secretary of this Society by the end of each calendar year preceding the year in which such delegates are elected to serve.

Sec. 2. One-fourth of the members of the House of Delegates registered, representing one-fourth of the county medical societies in the state, shall constitute a quorum of the House of Delegates. All meetings of the House of Delegates shall be open to members of the Society.

Sec. 3. The speaker shall preside at the meetings of the House of Delegates.

Sec. 4. The vice speaker shall officiate for the speaker in the latter's absence or at his request. In case of death, resignation, or removal of the speaker, the vice speaker shall officiate during the unexpired term.

Sec. 5. The speaker shall appoint members of reference committees from among the members of the House of Delegates. These committees shall consider and make recommendations to the House relative to resolutions, reports of officers, reports of commissions and committees, financial and other matters germane to the business of the House. The speaker shall also appoint a credentials committee and such other committees as deemed necessary.

Sec. 6. The House of Delegates shall elect delegates to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body.

Sec. 7. The House of Delegates shall have authority to create committees for special purposes and to appoint members of the Society who need not be members of the House of Delegates. Such committees shall report to the House of Delegates, and their members may be present to participate in the debate on their reports.

Sec. 8. It shall receive for appropriate action the annual reports of the treasurer, secretary, and chairman of the Board of Directors.

Sec. 9. Unanimous consent of the House of Delegates shall be required for the introduction of any new resolution or business not filed in proper form with the secretary's office of the Society two months before the first session of the House of Delegates. This section shall not apply to new business or resolutions presented by the Board of Directors or any member thereof, the constitutional officers, committees of the Society or of the House of Delegates, or officers of the House of Delegates.

Sec. 10. All questions of an ethical nature brought before the House of Delegates shall be referred to the Board of Directors without discussion.

CHAPTER III
Annual Election

Section 1. The House of Delegates, at its first session of the Annual Meeting, shall elect a Committee on Nominations consisting of one (1) delegate for each district, except

that in any district having five hundred (500) or more regular and special members, there shall be elected one (1) additional delegate for each additional five hundred (500) members or majority fraction thereof. One (1) delegate representing the specialty sections shall also be appointed. This committee shall become operative at the close of the final session of that Annual Meeting and shall function until the close of the final session of the following year's Annual Meeting. The incoming committee shall meet with the existent committee but without vote during the overlapping days of the Annual Meeting. Any vacancy occurring in the Committee on Nominations between the date of its formation and the time of its reporting shall be filled by appointment by the director or directors of the district in which the vacancy occurs, provided that if the vacancy occurs in the representation from the specialty sections, such vacancy shall be filled by ballot from among the section delegates.

The Committee on Nominations shall convene at least two (2) months prior to the Annual Meeting of the House of Delegates to prepare a slate of candidates. This meeting, to be held at a time, date and location published to the general membership at least two (2) months before this meeting, shall include an open session of not less than one (1) hour to allow individual nomination of candidates. The Committee shall report the result of its deliberations to the House of Delegates in the form of a ticket containing the names of one or more members for each of the positions to be filled.

Sec. 2. The report of the Committee on Nominations and elections shall be the first order of business of the House of Delegates at the third session of the Annual Meeting.

Sec. 3. The House of Delegates shall elect the president-elect, the treasurer, the speaker and vice speaker of the House of Delegates, and the delegates and alternates to the American Medical Association. Where there is no contest, a majority vote without ballot shall elect. All other elections shall be by separate ballot for each individual position, and a majority of the votes cast shall be necessary to elect. If no nominee receives a majority of the votes on the first ballot, the nominee receiving the lowest number of votes shall be dropped, except where there is a tie, and a new ballot taken. This procedure shall be continued until one of the nominees receives a majority of the votes cast.

Sec. 4. Nothing in this chapter shall be construed to prevent additional nominations being made from the floor by members of the House of Delegates.

CHAPTER IV
Duties of Officers

Section 1. The president is the chief constitutional officer of the Society. Within the limits of the Constitution, Bylaws, and policies of the House of Delegates and Board of Directors, the president shall have the following responsibilities and commensurate authority:

a. Deliver an annual address to the House;
b. Serve as a member with right to vote on the Board;
c. Preside at meetings of the Executive Committee of the Board;
d. Participate, ex officio and without the right to vote, in sessions of the House;
e. Initiate and propose policies and programs that will further the goals and objectives of the Society for consideration by the House, Board, commissions and committees;
f. Support and articulate policies and programs adopted by the Board and the House;
g. Promote physician interest and active participation in the Society.

Sec. 2. The president-elect shall act for the president in his absence or disability. If the office of president should become vacant, the president-elect shall succeed to the presidency. In case of vacancy in the office of both president and president-elect, the Board shall appoint one of its members as acting president until the next meeting of the House of Delegates.

Sec. 3. The treasurer shall be responsible to the Board of Directors, and shall advise and assist it in making decisions on investment policy and financial matters. The duties of the treasurer shall include the following:

a. Be responsible for all funds due the Society, together with bequests and donations;
b. Pay money out of the treasury only on written order of the secretary;
c. Subject the treasurer's accounts to such examination as the House of Delegates may order;
d. Annually report on the financial standing of the Society, including a balance sheet and income and expense report;
e. Give bond in such amount as the Board may provide.

Sec. 4. The secretary is the chief executive officer of the Society charged with the execution of policy as created and defined by the House of Delegates and the Board of Directors. Duties of the secretary shall include being secretary of and responsible to the Board; assisting the officers in making decisions and implementing actions; sharing convictions and arguing their merits as requested. Duties as chief executive officer shall be:

a. Assume the general managerial duties of all Society divisons, activities, and personnel;
b. Be custodian of all records and papers belonging to the Society, except such as properly belong to the treasurer;
c. Keep account of and promptly turn over to the treasurer all funds of the Society which come into the secretary;
d. Maintain current copies of each component county society's constitution and bylaws;
e. Conduct the official correspondence, notifying members of meetings, officers of their election and committees of their appointments and duties;
f. With the approval of the Board, employ such assistants as are needed to effectively execute the policies of the Society;
g. Make an annual report to the House of Delegates.

CHAPTER V
Board of Directors

Section 1. The Board of Directors shall be the executive body of the Society. Between meetings of the House of Delegates it shall exercise the power conferred on the House of Delegates by the Constitution and Bylaws.

Sec. 2. The Board shall meet during the Annual Meeting and at such other times as necessity may require, subject to the call of the chairman or on petition of three directors. It shall hold an annual meeting for purposes of organization and other business.

Sec. 3. The Board shall elect a chairman and a vice chairman from among its voting members. It may create such further offices or combine or abolish them as it sees fit in the management of its affairs and in the discharge of its responsibilities. Its chairman shall submit an annual report to the

House of Delegates including all major actions and policy decisions of the preceding year.

Sec. 4. Each director shall be the organizer and mediator for the district. Directors shall visit each county in their district as needed for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and to keep informed of the activities of the component societies in the district. Each director shall arrange for an annual conference or caucus with the societies or their delegates within the district, at which time information shall be disseminated concerning the activities of the State Medical Society and component societies within the district. Each director shall report as necessary to the Board. The necessary traveling expenses incurred by each director in the line of duties herein imposed may be allowed on a proper itemized statement, but this shall not be construed to include the expense of attending the Annual Meeting of the Society.

Sec. 5. The Board of Directors shall be the judicial body of the Society. It may decide any questions of conduct or discipline of members, or any questions involving the rights and standing of members, whether in relation to other members, to the component societies, or to this Society. It shall develop and publish procedures for discipline, including denial of initial or continuing membership, for those physicians who fail to provide quality health care, failure to pay dues, loss of license to practice, or other cause. Its decisions in all cases shall be final, including the right to expel a member should a component society fail to do so after being so requested by the Board.

The Board's right to original jurisdiction includes but is not limited to the right to decide cases when:

a. the affected parties reside within the boundaries of a single county medical society and that society does not wish to assume jurisdiction;
b. the affected parties reside in two or more component medical society jurisdictions.

The Board also has within its authority the right to appoint a commission or commissions to which any or all such matters may be referred for investigation, evaluation and decision to acquit, admonish, or otherwise discipline as appropriate. A member may appeal to the Board the decision of such commission or the action of a county society as provided in Chapter X, Section 3. If the recommendation is for suspension or expulsion of a physician from Society membership, final action must be taken by the Board.

Sec. 6. Charters shall be issued to county societies only on approval of the Board, with ratification by the House of Delegates, and shall be signed by the president and secretary of this Society. Upon the recommendation of the Board, the House of Delegates may revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and Bylaws.

Sec. 7. In sparsely settled sections, the Board shall have authority to organize the physicians of two or more counties into societies. These societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

Sec. 8. The Board shall provide for and superintend the issuance of all publications of the Society including proceedings, transactions and memoirs, and shall have the authority to appoint an editor of the Journal and such assistants as it deems necessary.

Sec. 9. The Board shall select a qualified independent accounting firm and receive an annual audit of all accounts of this Society. With the treasurer, it shall supervise the investment of funds. The Board shall adopt an annual budget providing for the necessary expenses of the Society.

Sec. 10. The Board may, by interim appointment, fill any vacancy in office not otherwise provided for which may occur during the interval between Annual Meetings of the House of Delegates. The appointee shall serve until a successor has been elected and has qualified.

When a district initially qualifies for an additional director, such position shall be considered new and not a vacancy to which the Board is authorized to make an interim appointment. Such new position shall be filled by election at the next meeting of the House of Delegates in the manner provided by Article VI of the Constitution. The initial term shall be so established as to maintain the election of substantially one-third of the directors each year.

Sec. 11. The Board may elect as secretary one who need not be a physician or a member of the Society.

Sec. 12. The formation of salary schedules of all employees of the Society shall be the responsibility of the Board.

Sec. 13. The Board shall provide such facilities for the Society as may be required to properly conduct its business.

CHAPTER VI
Commissions and Committees

Section 1. The Board shall appoint such commissions and committees, either permanent or ad hoc, as it deems necessary to properly conduct the affairs of the Society. Membership on such committees and commissions shall be limited to members of the Society and its Auxiliary. Nonmembers of the Society or its Auxiliary may be appointed as special representatives should their expertise and knowledge be of benefit to the goals of such commissions or committees. Such individuals shall not have the right to vote or hold office.

Each commission and committee shall have the duty of being informed on matters within the area of its special interest. They shall represent the Society's interests by continual contacts with voluntary and governmental agencies having related concerns with the intention of coordinating efforts to serve the health interests of the people of Wisconsin. They shall develop recommendations from their studies and activities for action by the Board or House of Delegates.

Sec. 2. Specialty sections shall be regarded as special committees of the Society from which the Board or any commission or committee may seek advice and assistance on matters of special or general concern to the profession and the health of the people of Wisconsin. The specialty sections will be expected to give special requests prompt consideration and response so as to enable the Society to make maximum use of their resources.

CHAPTER VII
Dues and Assessments

Section 1. The annual dues and assessments of this Society shall be determined by the House of Delegates and shall be levied per capita on the members. Dues and assessments shall be payable as determined by the Board of Directors. Any member whose current year's dues have not been received by the secretary of this Society by May 15 shall be deemed in arrears and his name shall be removed from the membership rolls of his county society and this Society until such time as full dues for the current year have been received.

Sec. 2. The record of payment of dues and assessments on file in the offices of this Society shall be final as to the fact of payment by a member and to the right to participate in the business and proceedings of the Society or the House of

Delegates and to any other benefits and privileges of membership.

CHAPTER VIII

The Board of Directors shall adopt ethical guidelines for the members of this Society.

COMMENT: On July 18, 1981 the Board of Directors adopted the Principles of Medical Ethics of the AMA as the ethical guidelines of the Society.

CHAPTER IX

The current edition of Sturgis Standard Code of Parliamentary Procedure governs this organization in all parliamentary situations that are not provided for in the law or in its charter, constitution, bylaws, or adopted rules.

CHAPTER X
County Societies

Section 1. All present county societies or those that may hereafter be organized in this state shall, upon application to the Board of Directors, receive charters from this Society, provided that their constitutions and bylaws have been submitted to the Board and found in conformity with the Constitution and Bylaws of the State Medical Society. All revisions shall be submitted to the Society, approved by the Board, and filed with the secretary. Where a county society has lost or misplaced its constitution and bylaws, the model constitution and bylaws for county medical societies, as last approved by the Board, shall be deemed to apply.

Sec. 2. Only one component medical society shall be chartered in each county.

Sec. 3. Any physician who may feel aggrieved by the action of the society of his county in suspending or expelling him shall have the right to appeal to the Board of Directors of the State Society. Its decision shall be final. A county society shall at all times be permitted to appeal or refer questions involving membership to the Board of the State Society for final determination. The mechanisms and procedures which apply to the appeal process shall be those adopted by the Board.

Sec. 4. Each component county society shall elect one or more delegates and may elect an equal number of alternates to substitute for any absent delegates from that component society, for a term of two calendar years, to represent it in the House of Delegates of this Society, in accordance with Chapter II, Section 1, of these Bylaws. The term of office shall begin on January 1 of the year succeeding the election of such delegates and alternates.

Sec. 5. The secretary of each county society shall keep a roster of its members.

CHAPTER XI
Specialty Sections

Section 1. The House of Delegates shall establish specialty sections within the Society. It shall have the power to combine, enlarge, or discontinue any or all of such sections so established.

Sec. 2. Such sections so established shall be based upon those divisions of medicine in which the various members possess a special interest. Qualifications for membership in any section shall be established by the members of such section, subject to approval of the Board of Directors. Scientific meetings of a section shall be open to all members in good standing of the State Medical Society.

Sec. 3. The officers of each section shall be elected by and from its membership. The terms of such officers shall be for one year, but any officer may be reelected.

Sec. 4. No section shall have the power to bind the State Medical Society by any resolution or other action. No such resolution or action shall be publicized unless it shall first have been approved by the House of Delegates, or by a majority of the Board when the House is not in session. No resolution adopted by any section shall be effective until likewise so approved.

Sec. 5. Each section shall elect a delegate and an alternate to the House of Delegates. The term shall be for two calendar years without limitation on number of terms.

Sec. 6. The specialty sections of the Society shall be considered an integral part of the working committee structure of the Society as outlined in Chapter VI of these Bylaws.

CHAPTER XII
Amendments

These Bylaws may be amended at any Annual Meeting by a majority vote of the delegates present at that session, if the proposed amendment has been properly submitted to the House of Delegates and has laid over for one day. ■

AMERICAN MEDICAL ASSOCIATION—PRINCIPLES OF MEDICAL ETHICS

PREAMBLE: The Medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility not only to patients, but also to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

I. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.

II. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.

III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

IV. A physician shall respect the rights of patients, of colleagues and of other health professionals, and shall safeguard patient confidences, within the constraints of the law.

V. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues and the public, obtain consultation, and use the talents of other health professionals when indicated.

VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.

VII. A physician shall recognize a responsibility to participate in activities contributing to an improved community.

MEDICAL ETHICS

CURRENT OPINIONS OF THE JUDICIAL COUNCIL of the American Medical Association, 1982. This new edition, originally compiled in 1958 and last revised in 1979, is intended as an adjunct to the revised Principles of Medical Ethics that were adopted at the AMA Annual Convention in 1980. The opinions are intended as guides to responsible professional behavior, but they are not presented as the sole or only route to medical morality. Behavior relating to medical etiquette, custom or usage is not included.

The following topics are included in the booklet:

- **Opinions on social policy issues**
  - Abortion
  - Allocation of Health Resources
  - Artificial Insemination
  - Artificial Insemination: In Vitro Fertilization and Embryo Transplantation
  - Clinical Investigation
  - Costs
  - Fetal Research Guidelines
  - Genetic Engineering
  - Organ Transplantation Guidelines
  - Quality of Life
  - Terminal Illness
  - Unnecessary Services
  - Worthless Services
- **Opinions on Confidentiality, Advertising and Communications Media Relations**
  - Advertising and Publicity
  - Advertising and HMOs
  - Communications Media: Press Relations
  - Communications Media: Standards of Professional Responsibility
  - Confidentiality: Attorney-Physician Relation
  - Confidentiality: Computers
  - Confidentiality: Insurance Company Representative
  - Confidentiality: Physicians in Industry
- **Opinions on Practice Matters**
  - Appointment Charges
  - Clinics
  - Consultation
  - Contingent Physician Fees
  - Contractual Relationship
  - Drugs and Devices: Prescribing
  - Informed Consent
  - Laboratory Services
  - Lien Laws
  - Neglect of Patient
  - Patient Information
  - Substitution of Surgeon Without Patient's Knowledge or Consent
- **Opinions on Hospital Relations**
  - Admission Fee
  - Assessments, Compulsory
  - Billing for Housestaff Services
  - Health Facility Ownership by Physician
  - Organized Medical Staff
  - Physician-Hospital Contractual Relations
  - Staff Privileges
- **Opinions on Physician Records**
  - Records of Physicians: Availability of Information to Other Physicians
  - Records of Physicians: Information and Patients
  - Records of Physicians on Retirement
  - Sale of a Medical Practice
- **Opinions on Professional Rights and Responsibilities**
  - Agreements Restricting the Practice of Medicine
  - Civil Rights and Professional Responsibility
  - Discipline and Medicine
  - Due Process
  - Free Choice
  - Patent for Surgical or Diagnostic Instrument
  - Peer Review
- **Opinions on Interprofessional Relations**
  - Nonscientific Practitioners
  - Optometry
  - Referral of Patients
  - Specialists
  - Teaching
- **Opinions on Fees and Charges**
  - Fees for Medical Services
  - Fees: Group Practice
  - Fee Splitting
  - Fee Splitting: Clinic or Laboratory Referrals
  - Fee Splitting: Drug Prescription Rebates
  - Insurance Form Completion Charge
  - Interest Charges and Finance Charges
  - Laboratory Bill
  - Surgical Assistant's Fee Competition

The State Medical Society of Wisconsin Board of Directors has adopted the AMA Principles of Medical Ethics as the ethical guidelines of the Society. The Society may refer to the Judicial Council Opinions for further guidance.

Copies of the *Opinions* are available by direct order to: Current Opinions (OP-122), American Medical Association, PO Box 821, Monroe, Wis 53566 (the distribution location of AMA publications).

The price is $5.00 each for 1-10 copies; $4.50 each for 11-49 copies; $4.00 each for 50 or more copies; $6.00 each outside the US. On orders of $10.99 or less, add $1.50; $11.00 or more, add $2.50. For special handling (UPS), add $3.00. Residents of Illinois, Wisconsin, and New York, please add appropriate state sales tax to total. ■

Expense reimbursement policy and procedure for physicians on State Medical Society business

Approved by Board of Directors, July 18, 1981

IT IS THE POLICY of the State Medical Society of Wisconsin to offer reimbursement of out-of-pocket expense incurred by its officers, directors, committee chairmen and members, AMA delegates and alternates and other designated physicians when such expense is incurred in the course of the conduct of business on behalf of the Society. The Society recognizes that any such leadership role requires a substantial contribution in personal time on the part of the physician. It is traditional that this be accepted as a contribution to the profession and the health of the public. However, out-of-pocket expenses in the discharge of official functions of the Society are reimbursable as set forth below:

Officers, Directors, Committee Chairmen and Members, and Other Designated Persons

Reimbursable expenses include the cost of:

1. All meals, including normal tips, incurred while away from the physician's home city on SMS business.
2. All meals in the home city of the physician when these are in relation to an SMS business meeting.
3. Entertainment expenses where such expense is clearly a proper and necessary adjunct to the conduct of the physician's business function for the Society.
4. Valet and laundry services when the physician is away from the home city on SMS business continuously for four (4) days or more.
5. Lodging for those days (nights) reasonably associated with the dates of a meeting for which expenses are claimed.
6. Transportation from home city to meeting site and return as follows:

   Air—Cost of round trip coach airfare, plus necessary ground transportation.

   Bus/Train—Cost of round trip fare, plus necessary ground transportation.

   Auto—Mileage at the current Society rate (now 20¢) to and from the meeting site, plus necessary parking fees and highway tolls.

   Miscellaneous Ground Transportation—Local bus and cab fares as necessary.

   Auto Rental—All or some portion of such cost may be reimbursed as a substitute for other ground transport when this is the most feasible alternative following initial air, bus or train travel. Example, remote resort meeting site.
7. Telephone and telegraph communications relative to SMS business.

   Note: Use of least costly means of telephone communication is encouraged. Examples: In calling SMS Headquarters use toll-free number 1-800-362-9080 whenever possible. Similarly, use direct dial rather than credit card, whenever feasible.
8. Secretarial and copying services, postage and stationery used for SMS business.

   Note: SMS Headquarters is prepared to handle most official correspondence and reproduction work for officers and committee members. However, physicians may be reimbursed for personal or office costs relating to secretarial, copying, postage and stationery utilized in conducting SMS business.

   Note: Copies of all official correspondence should be sent to the appropriate committee staff person at SMS so as to assure proper coordination and recordkeeping.
9. Expenses, as described in 1-8 above, incurred by the physician's spouse when accompanying him/her in an official capacity or when the spouse is "expected" to be in attendance are reimbursable.

Procedure for Claiming Expenses

1. To obtain reimbursement the physician must submit a statement of expenses incurred.
2. Attach copies of bills or receipts for all lodging, travel, and meals over $25.
3. Itemize separately costs for Item 8 above.
4. Mail to SMS, Attn: Accounting Department, PO Box 1109, Madison, Wis 53701.

Reimbursement will be made within two weeks following receipt and approval of the expense report.

AMA Delegates and Alternates

AMA Delegates and Alternates from Wisconsin receive reimbursement as follows for each meeting of the AMA House of Delegates they attend:

Round Trip Coach Airfare, or up to equivalent in auto mileage at the current SMS mileage rate (now 20¢).

$600 cash to cover out-of-pocket expense.

When such delegates and alternates are conducting SMS business not in conjunction with meetings of the AMA House of Delegates, their expenses may be reimbursed in the same manner as outlined for Officers, Directors, etc.

Out-of-State Trips

With the exception of AMA House of Delegates meetings and travel by the President/President-Elect, all out-of-state trips must have prior approval by the Executive Committee to be reimbursable. Contact the Secretary and General Manager. ■

4 DOZEN REASONS WHY YOU SHOULD STAY IN ORGANIZED MEDICINE

1. Low cost insurance programs such as—hospital-medical-surgical, life, disability, office protection, overhead expense.
2. SMS endorsed collection service.
3. Practice management and financial planning workshops.
4. Discounts on auto rental and leasing programs.
5. Regional continuing medical education conferences.
6. SMS Annual Meeting—offering top-notch scientific and socio-economic programs.
7. Protection of physician-patient interests in relation to Medicare, Medicaid, and other government programs.
8. Medical-legal information system.
9. Legislative liaison on up to 200 health-related bills each session.
10. Involvement in the political process through local Physicians Alliance committees.
11. Assistance on individual physician problems with the state's Medicaid program.
12. Continuous monitoring of the activities of the third-party health insurance carriers.
13. A cost containment effort to give doctors a voice in plans to contain health care costs.
14. Mediation and peer review system to handle patient grievances and assure quality medical care.
15. Physician placement service.
16. The *Medigram* newsletter.
17. A scientific journal: *Wisconsin Medical Journal.*
18. A Statewide Impaired Physician Program.
19. Physicians Alliance field consultants to help organize local political activity.
20. Physician referral service.
21. Negotiations with DHSS regarding physician reimbursement under Medicaid programs.
22. Toll-free member hotline to SMS Headquarters: 800-362-9080.
23. Statewide impaired physician program.
24. Comprehensive research reports on such issues as physician distribution, the Wisconsin public health system, and medical liability.
25. Monitoring of state/federal health planning laws.
26. Input into the Wisconsin State Health Plan.
27. Representing the physician's perspective in the Wisconsin certificate-of-need and decertification programs.
28. The Wisconsin Physician's Planning Network—your voice in health planning.
29. AMA/Wisconsin Jail Health Care Program.
30. Office furniture and book discount purchase plans.
31. Fort Crawford Medical Museum at Prairie du Chien.
32. Financial assistance for students in medical and allied health careers.
33. Charitable assistance to physicians and their families when personal hardship strikes.
34. Funding for scientific and socio-economic research projects.
35. Consumer Health Education Programs to promote a healthier Wisconsin citizenry.
36. Continual liaison with state media personnel to promote medicine's views.
37. A weekly health column currently carried in 90-plus Wisconsin newspapers.
38. Timely public service announcements.
39. Sponsorship of an annual Work Week of Health Program for high school students and health educators.
40. Liaison with Medical Examining Board.
41. Scientific speakers bureau.
42. Patient brochures for the doctor's office on a variety of health education topics.
43. Monitoring and comment on H-24, H-32 codes.
44. Accreditation program for hospitals and specialty societies to insure quality continuing medical education programming.
45. Participation in the rate setting process for WHCLIP and Patient Compensation Fund to assure equitable rates.
46. Consultation services on medical liability matters.
47. A strong commission/committee structure studying a variety of issues.
48. One-day conferences on socio-economic issues. ■

EMPLOYEES ALLOWED TO INSPECT RECORDS UNDER NEW LAW

PHYSICIANS AS WELL as other employers in the state should note the new personnel records inspection law which became effective May 21, 1980. The law gives the employee the right to inspect any employer-maintained personnel records used in hiring, promoting, transfering, giving raises, or terminating that employee as well as certain medical records. The employer is required to grant the employee at least two requests to view records per calendar year, each within seven days of the request, and at a location convenient to the employee during working hours, or other agreeable arrangement. Employers may require that request in writing.

An employee involved in a current grievance against the employer may designate in writing a representative, such as a union agent, to inspect the personnel records. Upon agreement of the employer and employee, any errors or differences of opinion may be noted in the record. If an agreement cannot be reached, the employee may add a written statement, to become part of the permanent file, expressing his/her opinion.

The employee may also inspect any of his/her medical records that are in the employer's file. If the employer feels these medical records would be detrimental to the employee, the employer may release them to the employee's physician or the employee's immediate family.

The employer may withhold some information under the law. Among the exceptions are: any records relating to possible criminal offenses, letters of reference, test documents (the employee may see the test scores), information about a third person, records relating to a pending legal claim between employer and employee, or material used by the employer for staff management planning. For complete details refer to Section 103.13, Wisconsin Statutes.

Life is short . . . Art is long . . . Experience is difficult

The Charitable, Educational and Scientific Foundation was established by the State Medical Society in 1955 to enable physicians and other friends of the profession to support, through gifts and grants, projects vitally affecting scientific medicine and public health. The Foundation's scope of interest has grown with increased volume of financial contributions to support a broad spectrum of programs affecting medical and health care needs in the State of Wisconsin.

Student Loans. The student loan program helps students finance their preparation for careers in medicine, nursing, dentistry, pharmacy, and allied health fields. Needy and deserving students may apply for and obtain loans carrying no interest until graduation. Since the program began nearly 750 students have received nearly $850,000 in long-term, low-interest loans. Of these, 446 students have completed their repayments.

Continuing Medical Education. Postgraduate teaching programs are a major thrust of the Foundation. Among these are a Speakers Service to county medical societies, the Wilson Cunningham, MD Memorial Lecture for public health, the Elvehjem Memorial Lecture for scientific speakers at the Annual Meeting, the Barbara Scott Maroney Memorial Fund for papers and lectures on diabetes, and the William D Stovall MD Memorial Fund and the Beaumont Memorial Lecture for general education and scientific medicine. Since 1975 the Foundation has been the vehicle for implementation of the accreditation of CME programming of Wisconsin hospitals and specialty groups. In 1982, 53 hospitals, 27 specialty groups, and one county society have been accredited for Category I CME.

Medical Student Externship Program. Fellowship grants from the Foundation make possible an eight-week externship with a family physician for students who have completed their freshman year of medical school. About 40 students, about one-half from each Wisconsin medical school, participate in this program each summer. The program is made possible through the cosponsorship of the Wisconsin Academy of Family Physicians and grants from supporting physicians and hospitals, and interested private organizations including the Wisconsin Rural Rehabilitation Corporation.

Research and Education. The Foundation plans, administers, and funds educational and research efforts of a scientific or medical-socioeconomic nature. One of these is the annual Wisconsin Work Week of Health aimed at health education of high school students and teachers, now in its 20th year. The Foundation also supports the Wisconsin Science Congress, the Wisconsin Children's Museum travelling exhibit, and promotion of infant car seats. In addition, its E E Bryant, Jr Memorial Fund promotes educational activity involving law, engineering and medicine, and the C H and J G Crownhart Memorial Fund supports activities involving medical-legal issues.

Charitable Assistance. Through the Foundation there is an opportunity for professional persons to assist their colleagues in need. Personal hardship strikes at physicians and their families as well as others.

Medical History. The Foundation, through a subsidiary group known as the Aesculapian Society, owns and operates the restored Fort Crawford Military Hospital and Medical Museum at Prairie du Chien. It is one of the unique educational and cultural institutions in the midwest—a tribute to all Wisconsin physicians and their role in securing good health for the people of the state. This three-building medical museum complex pays special tribute to William Beaumont, MD, who during the 1830s conducted experiments on the digestive process. More than 200,000 persons have visited the museum, which is a national historic landmark. Open from May through October, the museum depicts military and Indian medicine, important events in the history of medicine, replicas of physician and dental offices and pharmacies, and provides an array of health education exhibits including the transparent twins, health fads and fallacies, drug abuse, immunization, health and wellness, and the birth of a baby.

Opportunities for Giving. Gifts to the Foundation may take a number of forms: cash, life insurance, securities, land, books, instruments, stamp and coin collections, works of art, and other artifacts. Gifts may be unrestricted, restricted, or earmarked for specific purposes of interest to the donor. In addition, service can be provided to those who wish to establish a Living Trust by naming the Foundation as trustee. Use of this mechanism can result in an immediate tax advantage for the donor while providing a guaranteed income for life. The principal would revert to the Foundation upon death of the donor.

All types of contributions to this Foundation are tax-deductible.

Join the "Beaumont 500 Club"—See details on page 65

CHARITABLE, EDUCATIONAL AND SCIENTIFIC FOUNDATION
OF THE STATE MEDICAL SOCIETY OF WISCONSIN

THE FOUNDATION is a non-profit, non-stock corporation under Wisconsin statutes. Governing power is vested in a Board of Trustees composed of the Board of Directors and Officers of the State Medical Society of Wisconsin and up to 10 elected nonmedical persons. In addition each of the 55 component county societies may elect a representative who is considered a corporate member of the Board of Trustees. Although the membership of the Board of Trustees numbers over 90, the Officers and Executive Committee constitute an efficient working body in governing the routine affairs of the Foundation. The Officers of the State Medical Society, the Officers of the Foundation, and certain elected trustees constitute the Executive Committee of the Board of Trustees. A meeting of the entire Board is held at least annually. Officers are elected at that time. The Executive and other committees meet periodically throughout the year. The Foundation's organization insures continuing liaison at the county medical society level throughout Wisconsin and an integration with the governing body of the State Medical Society itself. Such an arrangement assures a personal and realistic approach to Foundation activities.

OFFICERS

PRESIDENT: R T Cooney MD, Portage—1982

VICE-PRESIDENT: S B Webster MD, LaCrosse—1982

TREASURER: L C Pomainville MD, Wisconsin Rapids—1982

SECRETARY: Mr E R Thayer, Madison—1982

BOARD OF TRUSTEES

OFFICERS AND DIRECTORS OF THE STATE MEDICAL SOCIETY OF WISCONSIN

A J Motzel Jr MD, Waukesha—1983
G C Kempthorne MD, Spring Green—1984
C P Erwin MD, Milwaukee—1985
Mr E R Thayer, Madison—1983
J J Foley MD, Menomonee Falls—1983
D A Treffert MD, Fond du Lac—1985
T T Flaherty MD, Neenah—1983
D W Taebel MD, LaCrosse—1983
V M Griffin MD, Mauston—1984
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W J Boulanger MD, Milwaukee—1984
T A Hofbauer MD, Menomonee Falls—1984
W H Konetzki MD, Waukesha—1984
I J Bruhn MD, Walworth—1984
Fredrick Wood Jr MD, Kenosha—1984
W L Treacy MD, Milwaukee—1984
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A O Tuftee MD, Beloit—1985
W P Crowley Jr MD, Madison—1984
P M Jackson MD, LaCrosse—1983
J J Kief MD, Rhinelander—1983
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R L von Heimburg MD, Green Bay—1983
I L Schroeder MD, Plymouth—1985
P S Haskins MD, River Falls—1983
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Mr George Becker, Fond du Lac—1984
The Honorable Kent C Houck, Richland Center—1984
Mrs Mary Hoard, Fort Atkinson—1983

CORPORATE MEMBERS REPRESENTING COMPONENT COUNTY MEDICAL SOCIETIES

Ashland-Bayfield-Iron: A A Koeller MD—1983
Baron-Washburn-Burnett: D E Riemer MD—1985
Brown: Vacancy—1983
Calumet: J L Jaeck MD—1985
Chippewa: J J Sazama MD—1985
Clark: K F Manz MD—1984
Columbia-Marquette-Adams: R T Cooney MD—1983
Crawford: E M Dessloch MD—1983
Dane: R A Graf MD—1983
Dodge: W E Funcke MD—1984
Door-Kewaunee: R G Evenson MD—1983
Douglas: Vacancy—1983
Eau Claire-Dunn-Pepin: G E Wahl MD—1985
Fond du Lac: Elizabeth Sanfelippo MD—1983
Forest: B S Rathert MD—1984
Grant: C L Steidinger MD—1983
Green: Vacancy—1983
Green Lake-Waushara: D J Sievers MD—1984
Iowa: H P Breier MD—1983
Jefferson: J S Garman MD—1984
Juneau: R F Farne MD—1984
Kenosha: H P Rafferty MD—1985
LaCrosse: L J Logan MD—1984
Lafayette: Vacancy—1983
Langlade: E J Roth MD—1985
Lincoln: J F Bigalow MD—1984
Manitowoc: J R Larsen MD—1985
Marathon: J G Sack MD—1984
Marinette-Florence: C E Koepp MD—1983
Milwaukee: J D Levin MD—1983
Monroe: G A Landmann MD—1984
Oconto: J S Honish MD—1983
Oneida-Vilas: J J Kief MD—1985
Outagamie: Paul Cunningham MD—1983
Ozaukee: R F Henkle MD—1985
Pierce-St Croix: D M Woeste MD—1985
Polk: John O Simenstad MD—1985
Portage: W C Sheehan MD—1984
Price-Taylor: J R Keuer MD—1985
Racine: F J Scheible MD—1985
Richland: R W Edwards MD—1983
Rock: J J Tordoff MD—1983
Rusk: William Bauer MD—1985
Sauk: H P Baker MD—1983
Sawyer: Vacancy—1985
Shawano: J J Albright MD—1983
Sheboygan: J R Pawlak MD—1985
Trempealeau-Jackson-Buffalo: O M Schneider MD—1984
Vernon: R A Starr MD—1984
Walworth: Vacancy—1985
Washington: J E Albrecht MD—1985
Waukesha: Vacancy—1984
Waupaca: J H Steiner MD—1984
Winnebago: George W Arndt MD—1983
Wood: L C Pomainville MD—1984

FACTS . . .
about the CES Foundation Student Loan Program

THE CHARITABLE, Educational and Scientific Foundation of the State Medical Society of Wisconsin is a nonprofit, nonstock Wisconsin corporation, which was chartered in June 1955. Its purpose is to "engage in, assist, and contribute to the support of charitable, educational, and scientific activities and projects and to contribute to the support of, and to create and maintain, charitable, educational, and scientific institutions, organizations, and funds of any and every kind.

Management: The Foundation's governing power is vested in a Board of Trustees composed of the Directors and Officers of the State Medical Society of Wisconsin and up to ten elected nonmedical persons. In addition, each of the 54 component county medical societies may elect a representative who is considered a corporate member of the Board. The Board meets at least annually. Routine affairs of the Foundation are directed by an Executive Committee consisting of the Officers of the State Medical Society, the Officers of the Foundation and certain elected Trustees.

Registration: The Foundation is registered with the Secretary of State as a charitable organization for purposes of contributions and fund-raising under Sec. 440.41 (2) Wis. Stats.

Legal: The Foundation retains Robert B L Murphy and W Pharis Horton of the firm of Murphy, Stolper, Brewster and Desmond, 150 East Gilman Street, Madison, Wisconsin 53703, telephone 608/257-7181, for advice on legal and tax matters.

Tax Information: Contributions to the CES Foundation are deductible under both state and federal tax laws. The Foundation is a 501 (c) (3) corporation.

THE GENERAL STUDENT LOAN FUND

One of the most important activities of the CES Foundation is the Student Loan Program. Established in 1955, the Foundation's General Student Loan Fund is designed to assist needy, deserving students preparing for careers in medicine, dentistry, pharmacy, nursing, and other allied health fields. These long-term loans are interest free until after the student's graduation. Personnel in the financial aids departments of Wisconsin's schools cooperate with the Foundation in identifying needy and deserving students. Only students enrolled in Wisconsin schools are eligible for Foundation loans. The General Student Loan Fund is supported by general contributions earmarked for student loans.

SPECIAL STUDENT LOAN AND SCHOLARSHIP FUNDS

Although the Foundation's primary emphasis is on loans, some outright scholarships (grants) are made to fulfill the wishes of some donors. These special health career student loan and scholarship funds are administered by the Foundation according to the wishes of the individual or organization establishing and supporting the fund.

For example, a county medical society auxiliary may make an original endowment to the CES Foundation to establish a student loan or scholarship fund in the county auxiliary's name. The county auxiliary, as the benefactor, may decide what restrictions, if any, it wishes to place on the loans. Such restrictions may include:

- County residency requirements.
- Career specifications—medicine only or what other health careers to be included.
- Schools to which loans will be granted—you may wish to limit the fund to local university.
- Any limit or year of study—freshman only, upperclass only.
- Restrictions on amount of each loan.
- Amount of original endowment for the Fund.
- Additional requirements.

In establishing a special student loan or scholarship fund with the Charitable, Educational and Scientific Foundation, the following points should be considered:

- The CES Foundation will furnish an accounting annually to the benefactor or sponsoring organization.
- Brochures, folders, or other literature concerning the Fund may be distributed by any interested organization or person.
- Application blanks may be procured from the CES Foundation, 330 East Lakeside Street, PO Box 1109, Madison, Wis 53701, the benefactor, or college financial aids office.
- Applications will be accepted and considered without regard to race, color, creed, or national origin.
- The decision to approve individual loan applications, amount of the loan, and terms of repayment will be made only by the CES Foundation and will be based on the need demonstrated and availability of funds.
- The Foundation may, at its discretion (a) accept additional contributions to the Fund, (b) accept accelerated payments of obligations to the Fund, (c) waive repayment in hardship cases, and (d) increase or decrease rates of interest as the demands for loans may dictate.
- The Foundation may invest and reinvest assets of the Fund in accordance with prudent investment policies, and any interest or appreciation earned by such investments will accrue to the Fund.
- Direct expenses incurred by the Foundation in administering the Fund will be charged to the Fund. (At the present time, by action of the Board of Directors of the State Medical Society of Wisconsin, all expenses incurred by the student loan funds administered by the CES Foundation are paid by the Society.)
- In the event it is mutually determined that the purpose for which the Special Loan or Scholarship Fund was established no longer exists, the remainder of the Fund will be turned over to the Board of Trustees of the CES Foundation to use for other charitable, educational, and scientific purposes.

To inquire how you or your organization can establish a Special Student Loan or Scholarship Fund, contact LaVerne Bartel, Administrative Director, CES Foundation, 330 East Lakeside Street, PO Box 1109, Madison, Wisconsin 53701; or phone 608/257-6781; toll-free in Wisconsin 1-800-362-9080. ■

First Class First Aid

Recommend

NEOSPORIN® Ointment
(POLYMYXIN B-BACITRACIN-NEOMYCIN)

- Broad-spectrum antibacterial
- Handy applicator tip

DESCRIPTION: Each gram contains: Aerosporin® (Polymyxin B Sulfate) 5,000 units, bacitracin zinc 400 units, neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and ½ oz and 1/32 oz (approx.) foil packets.

INDICATIONS: *Therapeutically* (as an adjunct to systemic therapy when indicated), for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection. *Prophylactically*, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing

CONTRAINDICATIONS: Not for use in the eyes or in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

Wellcome / **Burroughs Wellcome Co.**
Research Triangle Park
North Carolina 27709

STATE MEDICAL SOCIETY OF WISCONSIN

Accreditation Program

for Continuing Medical Education

Information is available in printed form from either Bill Wendle, Scientific Affairs Coordinator, or Arlene Meyer, Administrative Assistant, Continuing Medical Education, State Medical Society of Wisconsin, PO Box 1109, Madison, Wis 53701; or telephone toll-free in Wisconsin 1-800-362-9080 (Madison area: 257-6781).

Representatives of the American Medical Association took the initiative to bring about the unification of a body responsible for accreditation of continuing medical education. This effort resulted in the adoption by the AMA House of Delegates at its Interim Meeting in December 1980 of the report of the Board of Trustees recommending the creation of the Accreditation Council for Continuing Medical Education (ACCME) and the bylaws for this new organization (which became operational January 1, 1981) and assumed the responsibility for national accreditation of organizations, institutions, and agencies offering continuing medical education. The state medical associations will retain the responsibility for accreditation of intrastate continuing medical education in accordance with the agreements reached in the creation of ACCME as stated in its bylaws.

The State Medical Society of Wisconsin's accreditation program functions under the authority of the AMA's newly created Accreditation Council for Continuing Medical Education (ACCME). Representatives from state medical societies, national medical specialty societies, AMA Section on Medical Schools and Resident Physician's Section, National Medical Association, American Hospital Association, Association for Hospital Medical Education, Federation of State Medical Boards, and medical specialty boards comprise the ACCME.

CATEGORY 1—CME activities with accredited sponsorship . . . Education activities that are a part of a planned program of continuing medical education and sponsored by an accredited organization . . . (including)

- Grand rounds
- Teaching rounds
- Departmental scientific meetings
- Seminars and Workshops
- Clinical Traineeships
- Mini-residencies
- Scientific sessions of medical specialty societies
- Visiting lecture programs
- Continuing medical education courses
- Audiovisual materials (under specified conditions).

CATEGORY 2—CME activities with non-accredited sponsorship (same activities as in Category 1, offered by a non-accredited medical organization. No formal approval is necessary for an organization to offer Category 2 credit).

CATEGORY 3—Medical teaching.

CATEGORY 4—Papers, publications, books, presentations, and exhibits.

CATEGORY 5—Non-supervised individual . . . activities (includes) self-learning, consultations, patient care review, self-assessment, specialty board preparation.

CATEGORY 6—Other meritorious learning experiences.

continued on opposite page

HELPING THE RETARDED, DEVELOPMENTALLY DISABLED PERSON

The family physician is very often the first person a family turns to when they suspect their child may be mentally retarded.

A resource the physician may wish to use in counseling the family is the local Association for Retarded Citizens. And a call to the local Unified Board or Developmental Disabilities Board will identify the resources that are available to a family in their county.

There should be local resources, psychological services, OT, etc available to complement the physician's examination. Also there are several clinics within the state that provide specialized evaluations for the persons who are mentally retarded and for persons with other developmental disabilities.

- **Child Development Center**
  Dr June Dobbs, Director, Child Development Center, Milwaukee Children's Hospital, 1700 West Wisconsin Ave, Milwaukee, Wisconsin 53201; (414) 931-4069

- **University Hospitals**
  Dr Charles Schoenwetter, H6 4th Floor, 600 Highland Ave, Madison, Wisconsin 53792; (608) 263-6421

- **Waisman Center on Mental Retardation**
  Linne Cain, Intake Coordinator, 1500 Highland Ave, Madison, Wisconsin 53706; (608) 263-5777

- **Comprehensive Evaluation Clinic for Multiple-Handicapped Children**
  Ms Marilyn Gratto, Miller-Dwan Hospital, 502 East 2nd Street, Duluth, Minnesota 55805; (218) 727-8762

Further information may be obtained from Merlen Kurth, Executive Director, Wisconsin Association for Retarded Citizens, Inc, 5522 University Ave, Madison, Wis 53705; (608) 231-3335.

CME Accreditation Program/*continued*

WISCONSIN INSTITUTIONS AND ORGANIZATIONS ACCREDITED *by SMSW and ACCME for continuing medical education programming at April 15, 1981*

Appleton Memorial & St Elizabeth Hospitals, Appleton
Bellin Memorial Hospital, Green Bay
Beloit Memorial Hospital, Beloit
Berlin Memorial Hospital, Berlin
Columbia Hospital, Milwaukee
Community Memorial Hospital, Menomonee Falls
Eagle River Memorial Hospital, Eagle River
Ft Atkinson Memorial Hospital, Ft Atkinson
Gundersen Medical Foundation Ltd & La Crosse Lutheran Hospital, La Crosse
Hartford Memorial Hospital, Hartford
Howard Young Medical Center, Woodruff
Kenosha Memorial Hospital, Kenosha
Lakeland Hospital, Elkhorn
Langlade County Memorial Hospital, Antigo
Luther Hospital, Eau Claire
Lutheran Hospital, Milwaukee
Madison General Hospital, Madison
Memorial Hospital of Iowa County, Dodgeville
Memorial Hospital of Oconomowoc, Oconomowoc
Methodist Hospital, Madison
Mount Sinai Medical Center, Milwaukee
Osseo Area Municipal Hospital, Osseo
Reedsburg Memorial Hospital, Reedsburg
Sacred Heart Hospital, Eau Claire
Sauk Prairie Memorial Hospital, Prairie du Sac
Shawano Community Hospital, Shawano
Sheboygan Memorial & St Nicholas Hospitals, Sheboygan
St Agnes Hospital, Fond du Lac
St Alphonsus Hospital, Port Washington
St Catherine's Hospital, Kenosha
St Clare Hospital, Baraboo
St Clare Hospital, Monroe
St Francis Hospital, Milwaukee
St Francis Hospital, La Crosse
St Joseph's Hospital, Chippewa Falls
St Joseph's Hospital & Marshfield Clinic, Marshfield
St Joseph's Hospital, Milwaukee
St Joseph's Community Hospital, West Bend
St Luke's Hospital, Milwaukee
St Marys Hospital Medical Center, Madison
St Mary's Hospital, Milwaukee
St Mary's Hospital, Rhinelander
St Michael Hospital, Milwaukee
St Michael's Hospital, Stevens Point
St Vincent Hospital, Green Bay
Stoughton Hospital Association, Stoughton
Theda Clark Memorial Hospital, Neenah
Trinity Memorial Hospital, Cudahy
Veterans Administration Medical Center, Tomah
Watertown Memorial Hospital, Watertown
Waukesha Memorial Hospital, Waukesha
Wausau Medical Center, Wausau
West Allis Memorial Hospital, West Allis
Winnebago Mental Health Institute, Winnebago

American Cancer Society, Wisconsin Affiliate
American Heart Association, Wisconsin Affiliate
Fox Valley Academy of Medicine
Madison Academy of Internal Medicine
Milwaukee Academy of Medicine
The Milwaukee Academy of Surgery
The Milwaukee Gynecological Society
Milwaukee Ophthalmological Society
Milwaukee Orthopaedic Society
The Racine Academy of Medicine
State Medical Society's Section on Ophthalmology
Wisconsin Academy of Family Physicians
Wisconsin Allergy Society
Wisconsin Association for Perinatal Care
Wisconsin Clinical Cancer Center
Wisconsin Dermatological Society
Wisconsin Neurological Society
Wisconsin Orthopaedic Society
Wisconsin Otolaryngological Society
Wisconsin Psychiatric Association
Wisconsin Surgical Society
Wisconsin Urological Society
Wisconsin Society of Obstetrics & Gynecology
Wisconsin Society of Pathologists
Wisconsin Society of Plastic Surgeons
The Wisconsin Society of Radiation Oncologists

Marinette-Florence County Medical Society

AMA Accredited
Dept CME, Medical College of Wisconsin
Dept CME, UW Center for Health Sciences
Interstate Postgraduate Medical Association
The State Medical Society of Wisconsin
Wisconsin Society of Anesthesiologists

MEMBERSHIP FACTS

ARE YOU A MEMBER of the State Medical Society of Wisconsin, or do you know someone who isn't? Whether you're just starting medical school, maintain a full-time practice, or are retired, SMS has a membership classification to fit your individual needs. Election to membership by the County Medical Society in which your principal place of practice is located carries with it membership in the State Medical Society of Wisconsin and, if you wish, the American Medical Association. If you qualify for resident membership at the time of your election, your membership dues are greatly reduced. This may also qualify you for reduced dues the first two years of your practice. Dues for regular membership are $410 for SMS, $285 for AMA, and county society dues vary. A more detailed listing of SMS membership classifications and their corresponding dues follows:

State Medical Society of Wisconsin

DESCRIPTION OF DUES CLASSIFICATION CODES

Regular: Member in active practice. Some are regular members that have reduced SMS and/or AMA dues because they are new practitioners (first year or two out of residency).

Resident: Physician who at January 1 of dues year is in an approved training program as a hospital resident or research fellow who is licensed to practice medicine and surgery in Wisconsin.

Military Service: Members who are serving in the U.S. armed forces (generally not to exceed five years).

Associate: Member whose dues are waived because of illness or financial hardship. This classification is temporary and is reviewed on an annual basis.

Life: Member who has held membership in a state medical society for 50 years or is a Past President of the State Medical Society of Wisconsin.

TO: State Medical Society of Wisconsin, Membership Dept, PO Box 1109, Madison, Wisconsin 53701

YES, I am interested in organized medicine. Please send me more information about the benefits of membership.

NAME _____

MAILING ADDRESS _____

_____

_____

COUNTY (principal practice located) _____

_____

Honorary: Member who was named by the Board of Directors in recognition of long and distinguished service to the cause of medicine.

Retired: Member who has completely retired from practice (works less than 240 hours per year). All dues are waived unless county society indicates they wish to charge county dues.

Part-time Practice: Physician, regardless of age, who practices 1,000 hours or less during the calendar year but does not qualify for retired membership.

Over Age 70: Member in active practice who is over 70 years of age.

Candidate: Member attending a medical school in Wisconsin or fulfilling a postgraduate obligation prior to eligibility for licensure.

Scientific Fellow: Member who is engaged in teaching one or more of the basic sciences at an accredited college or university, and not holding the degree of Doctor of Medicine or Osteopathy.

Emeritus: Retired members who have chosen not to renew their license.

1982 DUES AMOUNTS FOR THESE CLASSIFICATIONS

	SMS	AMA	COUNTY
Regular	$410	$285	Normal County Dues
Resident	41	35	Varies
Military Service	-0-	285 or 35	-0-
Associate	-0-	-0-	-0-
Life	-0-	-0-*	-0-
Honorary	-0-	-0-*	-0-
Retired	-0-	-0-*	-0-
Part-time Practice	205	285*	Normal County Dues
Over Age 70	205	-0-*	Normal County Dues
Scientific Fellow	-0-	-0-	
Emeritus	-0-	-0-*	
Candidate—			
Freshman Year Medical Student	-0-	15	Varies
Sophomore and Succeeding Medical Student Years	10	15	Varies
Postgraduate—One	10	35	Varies

*Due to recent policy changes by the AMA, future exemptions from AMA dues will be given to those physicians who are over 70 years of age *and* are retired from practice or practice 1000 hours or less a year.

State Society dues are prorated on a monthly basis for those elected to membership July 1 through September 30. Those elected after September 30 have no dues payable for the balance of the year in which they are elected. AMA dues follow the same pattern except prorating is on a semiannual basis rather than monthly basis.

To begin the membership process, if your practice is or will be located in Wisconsin, complete the form at left. If you have any questions, you may contact your local county society or call the toll-free number of the State Medical Society: 1-800-362-9080 (Madison area number: 257-6781). ■

THE FOLLOWING constitutes the summary report of actions taken at the Annual Meeting of the House of Delegates, May 13-14, 1982, in Milwaukee. Resolutions and reports were widely distributed to delegates, alternates, county society officers, and others. Members of the Society may, upon request, study the official transcript of the meeting at the State Medical Society headquarters in Madison, or inquire as to the full content of a particular report or resolution.

—*Earl R Thayer,* Secretary

SUMMARY REPORT, HOUSE OF DELEGATES
State Medical Society of Wisconsin, May 13-14, 1982

THE HOUSE DELIBERATED 39 resolutions as well as reports of officers, the Board of Directors, commissions, committees and ad hoc committees. Refer to the April 1982 *Wisconsin Medical Journal* for abstracts of resolutions 1 through 36 and their sources. Following is the text of the House of Delegates reference committee reports (with additional commentary inserted where needed for meaning) and indication of House action upon committee recommendations.

REFERENCE COMMITTEE ON SCIENTIFIC ACTIVITIES

• **Report A** of the Commission on Continuing Medical Education outlines activity in accrediting CME providers, the Society's own accreditation, and annual meeting programming. Your Reference Committee notes the selection of Edwin L Overholt, MD, as recipient of the Interstate Postgraduate Medical Association Award and George Magnin, MD, as recipient of the Distinguished Service Award and commends the Committee for recognizing these two fine educators.

Action: Adopted

• **Report H** of the Committee on Aging and Extended Care Facilities presents a Statement on Terminal Care in Long-Term Care Facilities and your Reference Committee recommends that the House recognize the growing importance of this subject.

Action: Adopted

• **Report I** of the Committee on Alcoholism and Other Drug Abuse outlines work on Department of Health and Social Service Standards for Alcohol and Other Drug Abuse Programs, input on the 1982 State Health Plan, support for legislation concerning drinking and driving and concern with assessment procedures mandated in the new law. Guideline Admission Criteria for Chemical Dependency Treatment Services, developed by the Committee, was attached to the report. The Reference Committee supports the Committee's recommendation for medical assessment of drivers arrested for OWI and its recommendation encouraging education on chemical dependency at the medical school level.

Action: Adopted

• **Report K** of the Committee on Maternal and Child Health covers action concerning premarital physicals, birth certificates, rubella immunization, and presents the Revised Statement on Oxytocics developed by the Committee. Your Reference Committee recommends to the Committee that it continue to study the issue of sexually transmitted diseases.

Action: Adopted

• **Report L** of the Committee on Medicine and Religion discusses the Medicine and Religion Breakfast and plans for the coming year.

Action: Adopted

• **Report N** of the Committee on Safe Transportation outlines support for legislation concerning drinking drivers and child passenger restraints, and other actions supporting child passenger restraints, mandatory motorcycle helmet use, and driver warnings on AMA Patient Medication Instructions. The Committee also reviewed Department of Transportation Administrative Rules on medical requirements for school bus operators and driver licensing of persons who have experienced episodes of altered consciousness or loss of body control. The Reference Committee wishes to stress to the Committee that in view of the expanding elderly population, the Committee continue to address, in an expeditious manner, the issue of driving ability of the elderly.

Action: Adopted

• **Report O** of the Committee on Women Physicians covers organization of the Committee, study of Premenstrual Syndrome and sexual harassment, a meeting of women physicians at the district level, and plans for a seminar on "Politics of Organized Medicine."

Action: Adopted

• **Report D** of the Commission on Mediation and Peer Review covers disposition of patient complaint cases and peer review requested by commercial carriers and T-18. The report reviews activity of the Medicaid Medical Audit Committee, the Impaired Physician Program including the seminar presented

in October 1981, and listed objectives for the coming year. The Reference Committee wishes to commend Doctor Kempthorne for his services as chairman of the Commission and for his implementation of the Impaired Physician Program.

Action: Adopted

• **Section B** of the **Supplementary Report of the Board of Directors** concerns Utilization Review, recommending that on the subject of voluntary medical peer review the policy of the State Medical Society of Wisconsin shall be to continue professionally directed efforts to ensure that care provided to patients is of high quality, appropriate duration, and is rendered in an appropriate setting at a reasonable cost; and to encourage continued physician direction of peer review programs including PSRO.

Action: Adopted

• **Resolution 39** deals with PSROs. The committee recommends that Resolution 39 be referred to the Board of Directors for clarification and coordination with Section B of the Supplementary Report of the Board of Directors.

Action: Referred

• **Resolutions 1 through 5** related to the concept of no allowable blood alcohol concentration for persons who are driving. Because the Reference Committee felt that the concept of the resolutions is embodied in Resolution 5, it is recommended that Resolutions 1, 2, 3, and 4 not be adopted, and that Resolution 5, "that the State Medical Society of Wisconsin go on record as being in favor of no allowable blood alcohol level in any driver on Wisconsin highways," be adopted.

Action: Adopted

• **Resolution 6** advocates raising the legal drinking age to 21. The Reference Committee recommends support of this resolution which strengthens previous House of Delegates actions in support of this concept.

Action: Adopted

• **Resolution 7** encourages reenactment of a motorcycle helmet law. Your Reference Committee heard Doctor Sandmire express support for an educational program and recommends that this be referred to the Board of Directors for consideration.

Action: Adopted and referred

• **Resolution 23** deals with recommendations for making jogging facilities available to the public. The Reference Committee recommends deletion of the first two resolves and adoption of the third resolve, amended to read, "RESOLVED, That athletic directors, coaches and municipal authorities be encouraged to make jogging facilities available to persons wishing to use them."

Action: Adopted

• **Resolution 24** proposes educational endeavors with physicians on spouse abuse and interaction with hospitals, community groups and other professional helping agencies on approaches to identification and care of spouse abuse victims. The Reference Committee wishes to commend the Medical Student Section for submitting a resolution dealing with this timely topic and recommends adoption.

Action: Adopted

• **Resolution 25** concerns tuberculin surveillance. The Reference Committee recommends that the resolve be revised to read, "That the State Medical Society request that the Department of Health and Social Services appoint an ad hoc committee in-

Attendance: 1393

Total attendance of the two-day scientific program, May 13-15, 1982 at MECCA in Milwaukee was 1393.

Registration of physician members was 844, 20 nonmember physician registrants, and 45 guest physicians, while the balance consisted of 241 technical exhibitors; 10 scientific exhibitors; 102 interns, residents, and medical students; and 114 guests (certified nurses, physician spouses, and others).

The three sessions of the House of Delegates had the following registrations: 123 first session; 124 second session; and 121 third session. There are 163 voting members of the House.

Credentials Committee
Dean D Miller, MD, Milwaukee, *Chairman*
John E Thompson, MD, Nekoosa
Edward A Burg, Jr, MD, Milwaukee

Hartzler delivers Elvehjem Lecture

Geoffrey O Hartzler, MD, Kansas City, Missouri presented the 1982 Elvehjem Memorial Lecture May 15 during the Internal Medicine program at the SMS Annual Meeting at MECCA. Doctor Hartzler spoke on "The Use of Lytic Agents in the Treatment of Coronary Artery Occlusive Disease."

The Elvehjem Memorial Lecture was established in 1962 to honor the memory of Dr Conrad A Elvehjem, the 13th president of the University of Wisconsin and an international authority in biochemistry. A project of the State Medical Society's Charitable, Educational and Scientific Foundation, the lecture is designed to perpetuate Doctor Elvehjem's contributions to the betterment of the health of the people of Wisconsin and the continuing medical education of physicians. ■

cluding appropriate medical authorities to review the current tuberculosis surveillance regulations with specific attention to the cost effectiveness of required annual chest x-rays so as to determine if revised, updated regulations are in order."

Action: Adopted

• **Resolution 29** supports employment relationships between physical therapists and physicians. The Committee notes that a recent opinion of the Attorney General has upheld the right of physical therapists to be employed by physicians, but feels the resolution should be adopted because it succinctly states the Society's position.

Action: Adopted

REFERENCE COMMITTEE ON SOCIOECONOMIC ACTIVITIES

• **Report B** of the Commission on Governmental Affairs outlines legislative issues considered by the Commission during the past year. The 1982 Special Annual Meeting Edition of *Capitol Week* supplements this report. The Federal Legislation Committee portion of Report B has been reviewed by another Reference Committee. We recommend adoption of the portion of Report B specific to the Commission on Governmental Affairs and the *Capitol Week* supplement and give the Commission special commendation for its diligent and devoted service.

Action: Adopted

• **Report C** of the Commission on Health Planning describes the Commission's activities including its efforts to support the hospital and nursing home construction moratorium. The committee commends the Commission for its work and encourages the Commission to continue its efforts to institute health planning at the local level.

Action: Adopted

Maryland surgeon recipient of Beaumont Award

"Surgical Management of Benign and Malignant Biliary Strictures" was the title of the presentation made by John L Cameron, MD May 15 at the 1982 William Beaumont Memorial Lecture. Doctor Cameron is a professor of surgery at the Johns Hopkins Medical School in Baltimore, Maryland.

Established by the State Medical Society of Wisconsin in 1957, the William Beaumont Memorial Lecture is designed to present to members of the Society, distinguished medical scientists whose research and clinical experience may enrich the knowledge and skills of Wisconsin practitioners.

The lecture is given each year during the surgery meeting of the State Medical Society's Annual Meeting in Milwaukee. ■

Outstanding medical students receive Houghton Award

The Houghton Award of the State Medical Society's Charitable Educational and Scientific Foundation is given yearly to two senior medical school students who "through scholastic excellence, extracurricular achievement, and interest in medical organization show high promise of becoming a complete physician."

This year's recipients are Gabriella Coletti of the Medical College of Wisconsin and Robert C Homburg of the University of Wisconsin Medical School.

The award, consisting of a check for $100 and a plaque, was presented to Ms Coletti May 13 during opening session of the SMS House of Delegates. Mr Homburg was out-of-state and therefore was unable to be present to personally accept his award.

A native of Brookfield, Wisconsin, Coletti received her undergraduate degree from the University of Wisconsin-Milwaukee. She worked as a medical technologist at Mount Sinai Medical Center before enrolling at the Medical College of Wisconsin in September 1978.

Coletti has been active in a number of school activities throughout her four years of medical school. She has served as her class representative to the MCW Student Affairs Committee for the past three years and served as its chairman during the past year. She is a member of Alpha Omega Alpha, the national medical honor society.

A native of Madison, Wisconsin, Homburg received his Bachelor of Sciences degree, with a major in physics and mathematics, from the US Air Force Academy in 1973. A Hall of Fame Scholar athlete in 1972, Homburg served in the Air Force as a football coach and as a systems analyst before entering medical school in 1978. This spring he will enter a residency in internal medicine at Spokane, Washington.

President of the UW Chapter of Alpha Omega Alpha, the national medical honor society, this year, Homburg is active in both school and community activities. He is a member of the medical school's family club, has taught Sunday School, and was a student representative to the Wisconsin Department of Health and Social Services, Student Loan Forgiveness Committee.

The Houghton Award was established in 1968 by the late John H Houghton, a Wisconsin Dells general practitioner, to emphasize high ideals for future physicians. Later, his brother, William J Houghton, a Milwaukee surgeon, added to the fund. ■

• **Report E** of the Physicians Alliance Commission outlines the current activities of the Commission including the change by DHSS in physician reimbursement in the Medical Assistance program as well as activities proposed for 1982-83 including the development of a major policy statement on the Title 19 program. The committee commends the Commission and its subcommittees for being alert and productive especially in the areas of cost containment.

Action: Adopted

• **Report J** of the Environmental and Occupational Health Committee outlines its activities including: publication of occupational exposure history forms in the *Wisconsin Medical Journal,* revision of the *Wisconsin Occupational Health Guide,* support for a formaldehyde standard of .1 part per million in human dwelling places, and support for Ground Zero Week in Wisconsin at an educational level. The Reference Committee commends the Environmental and Occupational Health Committee for its efforts in areas that are becoming increasingly important.

Action: Adopted

• **Report M** of the Committee on Mental Health describes the committee's activities including the legislative change concerning mental health service under the Medicaid program. The Reference Committee commends the Mental Health Committee for its efforts.

Action: Adopted

• **Report Q** of the Ad Hoc Committee on Health Practitioners presents the final report of the committee's deliberations. **Part D** of the **Supplementary Report of the Board of Directors** supports the report, but notes that the recommendations of this report are intended to deal only with the 12 disciplines enumerated in that report. The Reference Committee commends the Ad Hoc Committee on Health Practitioners deliberations.

Action: Both adopted

THANK YOU

The reference committees of the House of Delegates are to be commended for their thoughtful deliberations and thanked for a job "well done."

National Issues
Paul M Cunningham, MD, Appleton, *Chairman*
Robert F Purtell Jr, MD, Milwaukee
Kermit L Newcomer, MD, La Crosse
John D Riesch, MD, Menomonee Falls
Thomas G Dehn, MD, Milwaukee

Socio-Economic Activities
Marvin G Parker, MD, Racine, *Chairman*
Lucille B Glicklich, MD, Milwaukee
Raymond L Hansen, MD, Marshfield
Frank H Urban, MD, Milwaukee
Marwood E Wegner, MD, St Croix Falls

Scientific Activities
Stephen B Webster, MD, La Crosse, *Chairman*
Joseph J Mazza, MD, Marshfield
Richard W Biek, MD, Milwaukee
Michael P Mehr, MD, Marshfield
David L Nelson, MD, La Crosse

Organization and Finances
James D Kramer, MD, Wausau, *Chairman*
John J Beck, MD, Sturgeon Bay
Donald E Riemer, MD, Cumberland
Robert T Cooney, MD, Portage
Marshall F Purdy, MD, Janesville

Credentials
Dean D Miller, MD, Milwaukee, *Chairman*
John E Thompson, MD, Nekoosa
Edward A Burg Jr, MD, Milwaukee

Duane W Taebel, MD
Speaker

Presidential citation bestowed to Dorothy (Parks) Reinhardt

A State Medical Society employee Dorothy (Parks) Reinhardt was honored posthumously by the Society May 13 at the Presidents' Dinner with the Presidential Citation in appreciation of her great contributions to the medical society and to public health.

SMS President Albert J Motzel Jr, MD, Waukesha, presented the award plaque to Parks' husband, Bill Reinhardt, "in recognition of Parks' devoted service to medicine and the public health during her 19 years as an employee of the Society, for the inspiring enthusiasm she had for her work with the Charitable, Educational and Scientific Foundation and the Fort Crawford Medical Museum at Prairie du Chien, and, in particular, for her unshakable dedication in working to improve the quality and delivery of health care extended to persons incarcerated in Wisconsin jails."

Speaking of Parks and the attitude with which she approached her life and work, Doctor Motzel quoted a poem Parks carried with her: "Just for today I will be unafraid. Especially I will not be afraid to enjoy what is beautiful and to believe that as I give the world, so the world will give to me."

"Certainly we physicians, as well as all citizens in this state, are much better off for what Parks Reinhardt gave the world before she passed away in September of last year. We can only hope that we are able to give the world as much in the future."■

• **Resolution 8** recommends that the State Medical Society of Wisconsin through its House of Delegates reiterate unalterable opposition to any third party schemes to develop reimbursement formulas based on "uniform" schedules. The Reference Committee rejects Resolution 8 because the language is too restrictive and would inhibit discussions underway, at the request of the Department of Health and Social Services, regarding a change in physician payment methodology in the WMAP.

Action: Rejected

• **Resolution 16** recommends that the State Medical Society of Wisconsin institute a formal legal action against the Department of Health and Social Services (DHSS) in a further effort to have medical psychotherapy restored as a physician's service in the Medical Assistance Program. *Part A* of the *Supplementary Report of the Board of Directors* states that the Board, on recommendation of the Committee on Mental Health, has authorized proceeding with an injunction against the State of Wisconsin to halt the implementation of these regulations. The Reference Committee recommends that the House adopt Part A of the Supplementary Report of the Board of Directors which deals with the legal action already commenced on psychotherapy benefits under Title 19 in lieu of Resolution 16 *which is redundant at this time.*

Action: Reference committee recommendation adopted, with addition of the words in italics.

• **Resolution 17** relates to the Medicaid Second Opinion Program. The Reference Committee recommends adoption of Resolution 17, deleting the resolve clause and replacing it with the following paragraph: "RESOLVED, That the State Medical Society seek repeal of the second opinion program."

Action: Adopted

• **Resolution 18** recommends that the State Medical Society request the Legislature to provide state funding for full time local health departments, preventive medicine and health education.

Action: Referred to Board of Directors

• **Resolution 19** recommends that the State Medical Society of Wisconsin develop and propose legislation to limit the contingency fee of an attorney involved in a medical malpractice action to no more than twice the usual charge for time and other effort involved. The Reference Committee recommends referral of this Resolution to the Medical Liability Committee for further study because of the complexity of the issue.

Action: Referred

• **Resolution 20** relates to contingency fee arrangements. The Reference Committee recommends referral of Resolution 20 to the Medical Liability Committee for further study because of the complexity of the issue.

Action: Referred

• **Resolution 31** recommends that the State Medical Society of Wisconsin advise the Governor of Wisconsin that the current planning system has been unworkable, ineffective, costly, and beyond repair, and should be abandoned in favor of a local voluntary planning system that includes adequate physician input and participation.

Action: Adopted

• **Resolution 34** recommends that the State Medical Society strongly endorses the intent and provisions of the "Clean Indoor Air Act" now pending in the Wisconsin Legislature which would regulate smoking in public places. The Reference Committee recommends adoption of this Resolution with the following substitute resolve: "RESOLVED, That the State Medical Society should continue to endorse the intent and provisions of the 'Clean Indoor Air Act' which would regulate smoking in public places."

Action: Adopted

• **Resolution 35** recommends that the State Medical Society caution and urge the Governor of Wisconsin to withhold endorsement of the assumption of Medicaid by the federal government until such time as the true impact is known to all Wisconsin citizens.

Action: Adopted

Marshfield physician honored for teaching efforts

George E Magnin, MD, a Marshfield Clinic internist and director of the clinic's Internal Medicine Residency Program, received the Distinguished Service Award of the State Medical Society of Wisconsin May 13.

The award, which has been presented five times since its creation in 1964, was bestowed upon Doctor Magnin in recognition of his "outstanding contributions to the science and art of medicine during his 30 years as a University of Wisconsin Medical School preceptor and his many years of service as director of the Internal Medicine Residency Program at the Marshfield Clinic."

In presenting the award to Doctor Magnin, SMS Board of Directors Chairman Darold A Treffert, MD, Fond du Lac, said that Doctor Magnin takes a sincere interest in all his students and strives to make the residency years a truly meaningful experience that will prepare these individuals to become complete physicians. "Doctor Magnin serves as a continuing inspiration for those physicians entering the field of internal medicine," he said. ■

REFERENCE COMMITTEE ON ORGANIZATION AND FINANCES

• **Report of the President:** Doctor Motzel appeared and elaborated further on some of the subjects contained in his report. He stressed the need to continue working on cost containment of medical services and emphasized the need for doctors to stay involved in the utilization review process.

We commend Doctor Motzel on this report and for his many efforts as President for the last fourteen months.

Action: Adopted and printed in this issue

• **Report of the President-Elect:** The committee thanks Doctor Kempthorne for the eloquent presentation and looks forward to the coming year.

Action: Adopted and printed in this issue

• **Report F—Commission on Public Information:** The committee heard testimony on this report covering such items as medical marketing, communications guide revision and media relations.

Action: Adopted

Recipients of awards

presented by the

State Medical Society of Wisconsin 1982

DIRECTORS AWARD
Henry A Anderson, MD, Madison

PRESIDENTIAL CITATION
Dorothy (Parks) Reinhardt, Madison (posthumously)

DISTINGUISHED SERVICE AWARD
George E Magnin, MD, Marshfield

BEAUMONT MEMORIAL LECTURE AWARD
John L Cameron, MD, Baltimore, Maryland

ELVEHJEM MEMORIAL LECTURE AWARD
Geoffrey O Hartzler, MD, Kansas City, Missouri

HOUGHTON MEDICAL STUDENT AWARD
Gabriella Coletti (Medical College of Wisconsin)
Robert Homburg (University of Wisconsin Medical School)

FIFTY YEAR CLUB AWARDS
See special feature elsewhere in this issue

ERWIN R SCHMIDT INTERSTATE TEACHING AWARD
Edwin L Overholt, MD, LaCrosse

A complete listing of recipients of awards for the previous years can be found in the June 1979, June 1980, and June 1981 BLUE BOOK issues of WMJ. Further details of the 1982 awards appear in this issue.

• **Report G—1982 Editorial Board—Wisconsin Medical Journal:** Filed

• **Report R—Organizing For Effective Action** and **Resolution 38—Term of Office of County Medical Society Officers:** Doctor Flaherty and others were present to testify and explain some background. Resolution 38 proposes a uniform term of office for county society officers beginning in January. Report R suggests program format and organizational considerations for county societies.

Action: Both adopted

• **Report S—Report of the Secretary:** The committee wishes to thank Mr Thayer and the entire staff for a job well done.

Action: Adopted

• **Treasurer's Report:** We heard testimony from Doctor Foley, Doctor Nielsen, chairman of the SMS Board Finance Committee, and the independent CPA. We take note that reserves increased in 1981 to a point where they could fund 4.5 months of operating expenses and continue to endorse the objective of reaching six months operating expenses in these reserves.

We would like to commend the Treasurer and Finance Committee for their diligence in performing their respective tasks.

Action: Received

• **Year-End Membership Report:** Filed

ANNUAL MEETING

Scientific exhibit awards

The following scientific awards were given special merit during the 1982 Annual Meeting of the State Medical Society of Wisconsin:

Correction of Mitral Regurgitation Without Valve Replacement by Lawrence I Bonchek, MD and Gordon N Olinger, MD, Medical College of Wisconsin, Department of Cardiothoracic Surgery.

Radioisotope Techniques in the Diagnosis & Treatment of Coronary Disease by Burton Friedman, MD and M A Gani, MD, Nuclear Cardiology Associates, Milwaukee, Wisconsin.

Recent Advances in Microsurgery by James R Sanger, MD; Hani S Matloub, MD, and Reudi P Gingrass, MD, Medical College of Wisconsin and Veterans Administration Hospital, Wood, Wisconsin.

Tumors of Fatty Origin: Distinguishing Radiographic Characteristics by Thomas A Lange, MD; John M Hoffman, MD and Howard R Gould, MD, University of Wisconsin Center for Health Sciences.

• **SMS Services, Inc. Informational Report:** Filed

• **Report P—Board of Directors**

A. *1982 Budget*—we heard testimony on some of the controls that are used by the Finance Committee to monitor costs.
Action: Budget Adopted

B. *1983 Dues*—we heard testimony to the fact that the SMS Finance Committee of the Board saw fit to recommend a $20 dues increase which is 4.9% even though the all items CPI for last year was 8.9%. This will be the smallest increase in dues in several years and yet will be in keeping with the 1975 House action which directs taking into consideration the effects of inflation on the Society's budget.
Action: 1983 regular member dues increased $20 to $430

C. *1981 House Actions:* Filed

E. *Future Meetings:* Filed

• **Resolution 9—Voluntary Cost Containment** and **Resolution 36—Physician Reimbursement:** These resolutions were considered together. There was no sponsor present to testify on either, although others did speak to some of the efforts already undertaken by the Society. While the committee agrees with the concept of Resolution 9, we feel Resolution 36 better addresses the issue.

Furthermore, we recommend adoption of Resolution 36 retaining the first three RESOLVES and amending the fourth, as follows:

RESOLVED, That the House of Delegates of the State Medical Society of Wisconsin condemns actions by Blue Cross-Blue Shield United and other third party insurors that interfere with both the physician-patient relationships and the right of physicians to establish their own fees; and be it further

RESOLVED, That Blue Cross-Blue Shield United and other third party insurors cease the issuance of letters and other communications that mislead subscribers by suggesting that patients have no legal responsibility for their medical care; and be it further

RESOLVED, That Blue Cross-Blue Shield United and other third party insurors clearly inform potential subscribers that policies issued by the company pay claims for medical care according to rates determined by the insuror and not the individual physician; and be it further

RESOLVED, That the SMS undertake programs and efforts to inform Wisconsin physicians, employers and citizens that health insurance policies in which the insuror determines UCR are not necessarily "total" coverage policies; furthermore, that the Society inform all affected parties of the various avenues of recourse.

Action: Resolution 9 rejected; Resolution 36 adopted as amended

• **Resolution 37—Creation of Section on Gastrointestinal Endoscopy:** The committee heard testimony. We recommend this resolution be rejected.
Action: Rejected

REFERENCE COMMITTEE ON NATIONAL ISSUES

• **Report of AMA Delegation:** The committee recommends that the oral report by Henry F Twelmeyer, MD, which will be incorporated in the official transcript of this meeting, be accepted with commendation.
Action: Adopted

House of Delegates Nominating Committee

State Medical Society of Wisconsin

1982-1983

DISTRICT 1
Clifton E Peterson MD, 1400-75th St, Kenosha 53140
John D Riesch MD, PO Box 427, Menomonee Falls 53051
Kenneth M Smigielski MD, 3615 W Oklahoma Ave, Milwaukee 53215
Jerome J Veranth MD, 5605 Washington Ave, Racine 53406

DISTRICT 2
Sandra L Osborn MD, 1912 Atwood Ave, Madison 53704
James J Tydrich MD, 1313 W Seminary St, Richland Center 53581, *Secretary*

DISTRICT 3
Stephen B Webster, MD, 1836 South Ave, LaCrosse 54601

DISTRICT 4
John E Thompson MD, 315 First St, Nekoosa 54457

DISTRICT 5
Kenneth M Viste Jr MD, 100 Stoney Beach Rd, Oshkosh 54901, *Chairman*

DISTRICT 6
Robert T Schmidt Jr MD, 923 Eliza St, Green Bay 54301

DISTRICT 7
Merne W Asplund MD, 1518 Main St, Bloomer 54724

DISTRICT 8
Clarence M Scott MD, 318-21st Ave E, Superior 54880

SPECIALTY SECTIONS
Joel E Taxman MD, 1622 W Wisconsin Ave, Milwaukee 53233

• **Report of Committee on Federal Legislation:** Your committee recommends acceptance of this part of Report B from the Governmental Affairs Commission which reviews Reagan Administration proposals and several others considered by the committee in the past year.

Action: Adopted

Directors Award presented to Doctor Anderson

Henry A Anderson, MD, Madison, received the highest honor of the State Medical Society of Wisconsin, the Directors Award, May 13 during the President's Dinner at the Annual Meeting in Milwaukee.

Doctor Anderson is the 47th recipient of the award which is granted only on occasion to those "who have served with outstanding distinction the science of medicine, their fellow physicians, and the public."

A graduate of the University of Wisconsin Medical School, Doctor Anderson is a native of Ephraim, Wisconsin. After an internship delayed by a bout with tuberculosis, he became a member of the staff of Pinehurst Sanatorium in Janesville. In 1941 he was named medical director of the River Pines Sanatorium at Stevens Point, Wisconsin, a position he held for 30 years.

Dr Anderson

While in Stevens Point, he established and became medical director of the student health services at the Wisconsin State College there and he served as a tuberculosis consultant to the Wisconsin State Board of Health. For 30 years Doctor Anderson was on the board of directors of the Wisconsin Lung Association.

As chairman of the Wisconsin Committee for the Control of TB, he was the leading edge of a movement to change Wisconsin's emphasis in the prevention, diagnosis and treatment of TB. For 21 years Doctor Anderson served as chairman of the State Medical Society Committee on TB and Chest Diseases.

From 1971 until his retirement in December 1981, Doctor Anderson served as medical director of the State's total and permanent disability program under Social Security.

In presenting the award to Doctor Anderson, State Medical Society Board of Directors' Chairman Darold A Treffert, MD, Fond du Lac, said: "In every task he undertook, Doctor Anderson displayed a dedication for human concern and a passion for professional excellence while at the same time exuding a degree of warmth, good humor and kindness."■

• **Resolution 10** encourages communication between medicine, business and industry. Your committee recommends amendment and adoption of the resolve to read "That liaisons between medicine, business, industry, including representatives of both employers and employees, be formed throughout the State of Wisconsin at the county and at the state level."

Action: Adopted as amended

• **Resolution 11** proposes that medicine-business coalitions involve county and state cost effectiveness and cost containment committees in their work, and your committee recommends its adoption.

Action: Adopted

• **Resolution 12** concerns early return to work after disability or illness. Your committee recommends amendment and adoption of the resolve to read "That Wisconsin physicians pursue efforts in communicating with personnel managers and appropriate supervisors to insure that recovered employees have an early return to suitable work."

Action: Adopted as amended

• **Resolution 13** proposes the offering of deductibles and co-payment in SMS sponsored insurance plans. Your committee notes that SMS Services, Inc has incorporated these features in the sponsored plan for members, but approves the resolution in principle and recommends its adoption.

Action: Adopted

• **Resolution 14** proposes that steps be taken to require deductibles and co-payment in all health insurance plans written in Wisconsin. Your committee notes that it is already the policy of this House by action in 1981 to urge that some form of contribution from the ultimate consumer of medical care, such as coinsurance or a deductible, be offered as an optional component of all health insurance policies. Your committee therefore recommends rejection of resolution 14.

Action: rejected

• **Resolution 15** concerns Medicaid Tax Credits. Your committee is in sympathy with the intent, but recommends that in lieu of adoption of resolution 15, the Board of Directors be requested to continue its study of the tax deductible medical assistance reimbursement proposal presented by the Wisconsin Academy of Family Physicians during 1981.

Action: Referred to Board

• **Resolution 21** concerns medical student loans and as introduced urges that physicians repay federal loans. Its author, the Dane County Medical Society, and the reference committee recommend adoption with deletion of the word "federal" in the first WHEREAS and in the RESOLVE, to then read as

amended: "that the State Medical Society strongly urge all practicing physicians to repay loans they received during the course of their medical training."

Action: Adopted as amended

• **Resolution 22** proposes publication of the names of physicians with unpaid loans from various sources. While the reference committee agrees that vigorous efforts should be pursued to collect past due student loans, it feels that the publishing of names could create unnecessary embarrassment and perhaps even liability for the Society in the event of error, and therefore recommends that resolution 22 be rejected.

Action: Rejected

• **Resolution 26** is entitled "preventing exposure to nuclear explosions." From the testimony and committee discussion, it was felt that the intent of the resolution was to refer to nuclear weapons and to explosions of such weapons, not to any peaceful uses of atomic energy. The committee recommends adoption of the following substitute resolve: "That the State Medical Society of Wisconsin announces its deep concern about the medical aspects of nuclear weapon explosions, encourages efforts to provide reliable scientific information to the profession and the public regarding the medical consequences of nuclear weapon explosions, and requests our public and professional representatives at the state, national and international levels to take whatever carefully considered steps are necessary to reduce the likelihood of nuclear weapon explosions.

Action: Adopted as amended

• **Resolution 27** proposes development of policy guidelines on the procedure of artificial insemination. Your committee recommends adoption of the resolution and referral to the Board of Directors.

Action: Adopted and referred

• **Resolution 28** urges that the Society play a more dynamic role in identifying, recruiting and promoting its own members for leadership positions in the AMA. Your committee recommends adoption.

Action: Adopted (with suggestion from the floor that this include residents)

Commission and committee appointments

The State Medical Society's Board of Directors May 15 appointed the following physicians to Society commissions and committees:

Commission on Continuing Medical Education
Charles L Junkerman, MD, Milwaukee
Thomas Simerson, MD, Merrill
Kenneth I Gold, MD, Beloit

Commission on Governmental Affairs
Geoffrey C Kloster, MD, Merrill

Commission on Health Planning
Jan E Erlandson, MD, Monroe
Michael E Tieman, MD, Berlin
Clarence R Hart, MD, Lake Geneva
John B Davis, MD, Verona
Peter L Eichman, MD, Madison

Commission on Mediation and Peer Review
Charles S Geiger, MD, West Bend
Sharon L Elias, MD, Milwaukee
Edsel G Doreza, MD, Walworth
Robert T Cooney, MD, Portage

Physicians Alliance Commission
John C Oujiri, MD, Ashland

Commission on Public Information
Robert J Goldberger, MD, Milwaukee
Roland D Paegle, MD, Milwaukee

Wisconsin Medical Journal—Editorial Board
George W Kindschi, MD, Monroe

Committee on Aging and Extended Care Facilities
Donna D Davidoff, MD, Milwaukee
Edward R Winga, MD, La Crosse
Kay E Jewell, MD, Milwaukee (resident)
Jovan L Djokovic, MD, Janesville

Committee on Environmental and Occupational Health
Erwin S Huston, MD, Milwaukee

Committee on Maternal and Child Health
Michael H Mader, MD, La Crosse
Gloria H Halverson, MD, Waukesha

Committee on Women Physicians
Carol Young, MD, Milwaukee
Chesley P Erwin, MD, Milwaukee
(President-elect, SMS, ex officio with vote)

Committee on Medicine and Religion
John B Weeth, MD, La Crosse
G Daniel Miller, MD, Oconomowoc
Donald A Wollheim, MD, Wauwatosa
Glenn H Franke, MD, Milwaukee
Dennis G Greer, MD, Wautoma

Committee on Safe Transportation
Kathryn P Nichol, MD, Madison
David K Dunn, MD, Milwaukee

Committee on School Health
Conrad L Andringa, MD, Madison ■

• **Resolution 30** proposes guidelines for fairness in competition. Your committee was impressed that the proposed guidelines contain many excellent ideas and recognizes the lack of guidelines in the current era of competition. However, from the testimony at the hearing it was clear there was not unanimity of opinion on a number of the proposed guidelines; your committee therefore recommends that action on this resolution be postponed to the 1983 annual meeting of the House of Delegates, and in the interim it be referred to the Board for further study, development, and recommendations.

Action: The House adopted a substitute motion that the proposed guidelines be referred to an ad hoc committee of the House of Delegates appointed by the Speaker instructed to review, amend as appropriate, and report with a final document for House consideration at the 1983 Annual Meeting.

• **Resolution 32** concerning the Federal Trade Commission proposes endorsement of HR 3722 and S 1984, and your committee recommends adoption.

Action: Adopted

• **Resolution 33** proposes endorsement of the federal "Comprehensive Smoking Prevention Education Act"—S 1929—and your committee recommends adoption.

Action: Adopted

* * *

In addition to reports and resolutions referred to committees and acted upon by the House, the delegates received a special informational report from the SMS Advisory Committee on Medicaid Fee Methodology, and the annual report from the Charitable, Educational and Scientific Foundation. ■

Baldwin woman assumes presidency of Auxiliary

Elaine Torkelson of 1380 Franklin Street, Baldwin, was installed May 13 as President of the Auxiliary of the State Medical Society of Wisconsin at an inaugural luncheon at the Hyatt Regency in Milwaukee.

Mrs Torkelson, who served as president-elect for the past year, succeeds Audrey Peterson of Madison as president of the organization representing about 2,000 physician spouses in Wisconsin.

A graduate of the University of Minnesota in English, Mrs Torkelson has held several posts in county and state medical auxiliaries. She is a past president of the Pierce-St Croix County Medical Auxiliary, has been editor of the State Medical Auxiliary newsletter—*Scan,* as well as having served on several state auxiliary committees.

The new president has also been active in her community. Chairman of the Baldwin Public Library for 18 years, Mrs Torkelson has served as a member of the Governor's Task Force for the Organization of Library Systems; organized a library for the patients of the Baldwin Community Service, and assisted in the establishment of a Wisconsin Library for the Blind and Physically Handicapped.

A Sunday School teacher for 15 years, she also implemented a foreign student program for the Baldwin-Woodville High School.

Mrs Torkelson currently is on the Board of Directors of the St Croix County Historical Society and was instrumental in organizing the Baldwin Centennial in 1978. In addition, she serves on the Managing Committee of the Fort Crawford Medical Museum in Prairie du Chien.

A mother of four, Mrs Torkelson is married to Leonard B Torkelson, MD, a Baldwin family physician. ■

CES FOUNDATION

CONTRIBUTIONS—MAY 1982

The Charitable, Educational and Scientific Foundation of the State Medical Society is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for May 1982.

Unrestricted

Winnebago County Medical Society Auxiliary; Waukesha County Medical Society Auxiliary; Fond du Lac County Medical Society Auxiliary; Raymond Headlee, MD; Jose Agpoon, MD; George H Bresnick, MD; William Wendle; SMS Members—*Voluntary Contributions*

Restricted

John Beasley, MD; McFarland Family Physicians—*Medical Student Summer Externship Program*

Memorials

Mrs. Stephen D Austin—*Sally Shepherd (Brown County Loan Fund)*

Maude Helen Kinney Estate—*B S Maroney (B S Maroney Memorial Fund)*

Dane County Medical Society—*L V Sprague, MD; G H Ewell, MD*

Mr-Mrs E Sturm; Mr-Mrs H Jensen; Mrs Betty Eckhardt; Mr Earl Monson—*Anna Kief*

State Medical Society—*Lindley V Sprague, MD; N Philip Anderson, MD; Harold J Dvorak, MD; James R Hoon, MD; Alex M Kane, MD; Edward J O'Brien, MD; Conrad W Giesen, MD* ■

THE FOLLOWING FINANCIAL STATEMENTS of the State Medical Society of Wisconsin are part of the Treasurer's Report to the House of Delegates. The Annual Certified Audit, prepared by Bailey, Calmes & Co, certified public accountants, is on file at Society headquarters. Members wishing to review the Audit may do so upon inquiry to the Secretary.

STATE MEDICAL SOCIETY OF WISCONSIN
Madison, Wisconsin
General Fund
STATEMENT OF INCOME AND EXPENSE
Year Ended December 31, 1981

INCOME	
Membership Dues	$1,582,660.55
Income from Invested Funds	181,415.32
Annual Meeting Income	35,775.00
AMA Grant for Study of Health Care in Correctional Institutions	12,647.00
AMA Collection Fees	14,354.21
Wisconsin Medical Journal Advertising, Subscription and Reprint Income	69,792.74
Mailing Labels	15,298.93
Equipment Rental	8,280.00
Contract Services Furnished Other Organizations	17,841.94
Other Income	8,685.42
TOTAL INCOME	$1,946,751.11
EXPENSES	
Payroll	$743,945.37
Payroll Related Costs	183,392.06
Cafeteria Expense	13,363.40
Travel Expense	138,010.38
Conference	56,539.58
Depreciation	17,156.16
Rent	88,076.96
Miscellaneous	6,341.06
Property Taxes	1,767.54
Repairs and Maintenance	3,167.56
Telephone	49,374.28
Postage	40,349.93
Printing and Supplies	152,545.66
Resource Materials	5,534.45
Association Dues	5,442.70
Grants and Appropriations	22,820.00
Outside Services	15,123.53
Mail Service	26,161.75
Data Processing Services	29,000.00
Certified Public Accountant Services	15,321.15
Legal Counsel	21,021.00
Speakers Expense	16,174.87
General Insurance	11,413.72
Provision for Bad Debts	1,220.00
WHCLIP Actuarial Expense	9,047.00
TOTAL EXPENSES	1,672,310.11
Excess Income Over Expense	$ 274,441.00

NOTES:

(1) This statement presents only the income and expense of the State Medical Society of Wisconsin (SMS) General Fund and is not prepared on a consolidated basis with SMS Realty Corporation or SMS Services, Inc. both totally controlled subsidiaries of the State Medical Society of Wisconsin.

(2) Intercompany transactions between SMS, SMS Realty Corporation, and SMS Services, Inc. have not been eliminated for the preparation of this statement.

STATE MEDICAL SOCIETY OF WISCONSIN
Madison, Wisconsin
General Fund
BALANCE SHEET
December 31, 1981

ASSETS		
Current Assets		
Cash		$ 12,253.90
Accounts Receivable—General	$ 25,607.03	
Less: Reserve for Doubtful Accounts	843.05	24,763.98
Due from Affiliated Organizations		62,289.10
Commercial Paper		935,629.16
Certificates of Deposit		390,000.00
Repurchase Agreement		655,000.00
Common Stock—At Cost (Market Value $7,533.75)		8,361.52
Accrued Investment Income Receivable		15,793.55
Employee Travel Advances		2,000.00
Prepaid Expenses		28,328.75
Supplies Inventory		11,124.28
Total Current Assets		$2,145,544.24
Fixed Assets		
Furniture and Equipment	$125,117.76	
Computer Software	23,701.50	
Subtotal	$148,819.26	
Less: Accumulated Depreciation	104,153.41	
Total Fixed Assets		44,665.85
Other Assets		
Investment in SMS Services, Inc.	$44,915.39	
Long Term Loan to SMS Realty Corporation	70,000.00	
Total Other Assets		114,915.39
TOTAL ASSETS		$2,305,125.48
LIABILITIES AND NET WORTH		
Current Liabilities		
Accounts Payable		$47,749.49
Dues Held for the Section on Ophthalmology		13,278.03
Dues Payable to the American Medical Association, County Medical Societies and Related Organizations		771.67
Accrued Payroll Taxes and Other Payroll Deductions		3,853.24
Accrued Property Taxes		1,767.54
Sales Tax Payable		102.93
Accrued Payroll and Vacation Pay		46,715.02
Unapplied Membership Dues		221.00
Accrued Miscellaneous Expense		2,641.75
Deferred Income:		
Prepaid Annual Meeting Income	$ 11,600.00	
Prepaid Membership Dues	1,543,528.75	1,555,128.75
Total Current Liabilities		$1,672,229.42
NET WORTH		
Surplus, January 1, 1981	$ 364,839.08	
Plus 1981 Income over Expense	274,441.00	
Subtotal	$ 639,280.08	
Less: Decrease in Value of Investment in SMS Services, Inc.	6,384.02	
Total Surplus December 31, 1981		632,896.06
TOTAL LIABILITIES AND NET WORTH		$2,305,125.48

President Kempthorne. . .

Report to the House of Delegates as President-elect

Our motto surely should be: "Not what the traffic will bear—but what the service is worth"

I AM A NATIVE SON of Wisconsin—born in the Dr Wilson Cunningham Hospital in Platteville, raised in Dodgeville and have practiced medicine in Spring Green for the last twenty years. My interest in organized medicine has been in the field of mediation, peer review and help for the impaired physician.

> *"I do solemnly swear. . .by that which I hold most sacred. . .that I will be loyal to the profession of medicine. . .and just and generous to its members. . .that I will lead my life. . .and practice my art. . .in uprightness and honor. . .that into whatsoever house I shall enter. . .it shall be for the good of the sick. . .to the utmost of my power."*

We all recognize the lofty calling of the Hippocratic Oath's beginning. I have always believed that physicians begin their careers with a sense of idealism. Ever since we received our calling to be physicians, we have been wrapped in the mantle of our great heritage. So many distinguished physicians have preceded us and left us with a great service to emulate. Every future doctor forms an ideal profile of himself or herself. Most envision, while young, an ideal program of things to do in life. The rest of that life is spent trying to fill in that profile with *achievements.*

Man is the only creature able to make tools with which to make other tools, and of all the tools made by him, *words* are surely the most important. Our profession involves learning, knowing, healing and teaching; and communication is so vital to each concept.

I received my calling to medicine when I was a small child. Psychiatrists would better understand my special kind of calling. As a small child, I learned of the tragic death of my seven-year-old brother—when I was but an infant of eight months. Over fifty years ago my older brother had an emergency tracheostomy for what was then called "membranous croup." His improvement was dramatic. Tracheostomy care in that small hospital was new and different for the nursing staff. The physicians instructed the staff to never leave the patient for fear of secretion build-up or problems with the tracheostomy in a seven-year-old child. Six o'clock the following morning—after many visits by my parents during the night—they called and inquired about his condition. They were told that he was doing fine. Tragically, one-half hour later they called and informed my parents that their seven-year-old son—and my only brother—*was dead.* No explanation. No conference with the doctors, only a request that the body be removed. Only with time did the truth come out. The frightened child had pulled his tube out and asphyxiated in the absence of the nurse. I am certain you can understand my *calling* and why I have been so active and dedicated to the Commission on Mediation and Peer Review.

History tells us that the earliest professions were theology, medicine, and law. These professions tried to minister to inexplicable moral afflictions, disease, lawsuits, and disputes. Medicine kept its purpose unchanged in the hands of physicians. Homer said: physicians were endowed with "knowledge beyond that of all other men." Clearly, I believe we all sense a calling to the profession. I doubt that many of us are here today who were not called to the lofty goals of this *grand* and *noble* profession.

Performance follows as a natural sequence to the calling. The great Greek poet Pindar wrote: *"Be what thou art."* What we are and what we do with our knowledge are what separates us from any other

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Presented before the House of Delegates of the State Medical Society of Wisconsin at its Annual Meeting, May 13-15, 1982, in Milwaukee.
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profession. Frank Lloyd Wright, being the consummate individualist, said:

> *"Quality means individuality—whether it be people or materials or buildings—each being itself in its own inherently different way. This might be called an attitude of 'making the most of everything,' which really means exploiting the differences—in things, in people, and in situations."*

So it is easy to see why he deplored the social creep toward conformity. And also why he had no use for the "self-made, self-willed, self-styled critics" who want to impose on the public their taste in aesthetic matters. He kept encouraging the public not to listen but to make up its own mind.

As physicians, we accept our professions as a service to mankind—not as a source of profit. When I first came to Spring Green, the elderly, sage banker in town taught me an early and important lesson.

After lending me the money I needed to open my practice in the new Frank Lloyd Wright designed medical building built by the people of the community, he proceeded to teach me the basic ingredient to cost containment. He said: "Doctor Kempthorne, you will never get rich by gouging people." I still have the privilege of caring for his 97-year-old widow, and I shall never forget his admonishment to me. It guides me in my daily determination of the cost of my service.

Our motto surely should be: "Not what the traffic will bear—but what the service is worth."

Crammed into the last generation were more advances than medicine had achieved in many entire centuries. Immunizations and antibiotics have kept millions of people out of hospitals. In my opinion the great advances of recent years have altered the destiny of man. There are no headlines for these great gifts to mankind. Do you realize that of all the people in the world who have *ever* lived to the age of 65, *one-half of them are living today?* We are all aware of that social condition. We also need to remind ourselves of our obligation to that special group. When I received an award from the Wisconsin Association of Nursing Homes, I stressed the importance of our *continuing* commitment to our patients as they age and when they enter nursing homes. This is the time when they need us more—not less!

Fortunately, in this enlightened day, our patients see us more as human—and less godlike. They realize that we are subjected to stresses similar to other humans and that we can be impaired also. The House of Medicine can be proud of its heroic efforts in seeking to help its sick brothers and sisters. Wisconsin can be very proud of the efforts of this Society in developing and maintaining an intense concern for the welfare of the sick doctor.

The human doctor-patient relationship will endure despite technologic advances and economic challenges, because the human aspect of medicine is important to both the doctor and the patient. Virtually nothing can remove that bond—unless we choose to abrogate that compassionate calling. There are those who would like to see us falter or fade from view. I recall so well a dear patient of mine who was dying of cancer at home. On one of my many visits she said to me: "Doctor Kempthorne, I know I am going to die, but I wonder how long it will take?" I have always remembered that dear lady's bravery despite her concern about the time it would take for death to overwhelm.

I can surely inform the world that the profession of medicine is stronger than ever—because the individual physicians within this great fraternity are performing well. We are respected, not out of an obligation, but because we are more deserving today. Unlike my dying patient, we, as an influential force in society, are not going to "die" nor will there be a waiting period to see if our image will suffer—because it will not.

In the *performance* of our duties as physicians, we are now aware of the need for patients to understand what we are doing and why we are doing it. Society expects and deserves more from us than any other profession. Our sensitivities bring us into closer and concerned patient care. We are increasingly becoming involved in our communities—establishing and maintaining relevancy and credibility with the people we serve.

Following the philosophy of "being what thou art" brings our careers to the *results* from years of performance. Every physician should leave a legacy of some sort—even if it is the lifelong demonstration of serving fellow humankind. The kind of legacy we will each leave will depend on the character and depth of our performance as physicians during our professional lives. We are and should be—professional people with the power of influence—not the image of affluence. I believe most of us want to complete our careers with the knowledge: "I have served." "I care." "I rendered the best care possible." "I shared my talents with my community." "I loved my work." The Spanish philosopher *Unamuno* wrote: "The vanity of the passing world kindles love in us, the only thing that triumphs over the vain and transitory, the only thing that fills life again and eternalizes it."

"In the performance of our duties as physicians, we are now aware of the need for patients to understand what we are doing and why we are doing it. Society expects and deserves more from us than any other profession."

There is little in life which is worthwhile when it is gained without effort. I recall as a boy growing up in Dodgeville, the time when two boyfriends and I were standing in front of the movie theatre contemplating our dilemma of being short one cent for admission. About that time, Frank Lloyd Wright

drove up and entered the theatre with his wife and several students. He overheard our economic woe and offered to buy our tickets to the movie. As the tickets were being purchased, he looked down at me and said: "Son, are you sure that your pride will not be offended if I buy your tickets?" Naturally, I quickly responded that we would not be offended—knowing full well we would have our own money to buy popcorn and candy. That was my only encounter with Frank Lloyd Wright, but it left a lasting imprint on my character.

"When we determine the basic needs of a patient, devoid of frills, we will be delivering appropriate care which can be challenged by any statistical inquisitor. No physician needs to fear an inquiry into his patient care plans, when he or she is guided by his conscience."

Our Hippocratic Oath concludes: "these things I do promise. . .and in proportion as I am faithful to this my oath. . .may happiness and good repute be ever mine. . .the opposite if I shall be forsworn.

Our State Medical Society was formed in 1841 and has as its purpose:

> *Bring together the physicians of the State of Wisconsin to advance the science and art of medicine and better the health of the people of Wisconsin and to secure the enactment and enforcement of just medical laws. We are physicians first, taught to prevent disease, relieve suffering and heal the sick.*

We don't seek to serve our patients as cost accountants. Nobody will project on a computer the amount of comfort, concern, and compassion we provide. Let us not be duped by the onus—"We are responsible for the high cost of medical care." Rather let us be guided by our conscience in the care and management of each, individual patient's needs.

When we determine the basic needs of a patient, devoid of frills, we will be delivering appropriate care which can be challenged by any statistical inquisitor. No physician needs to fear an inquiry into his patient care plans, when he or she is guided by his conscience.

The best *quality assurance* mechanism is our sensitivity quotient. If we individually cannot perceive our own abuse or neglect, then we have failed our calling. After a decade in the peer review field, I can tell you those kinds of physicians are *few* and *far* between! Dedicated physicians should strive to upgrade their wayward colleagues, rather than wait for the descent of the "system" to do it for them. We are and should be our brothers' helpers. I am truly saddened when I hear stories about bad doctors—but more saddened by the reluctance of colleagues to help for reasons of *apathy* or *fear of suit.*

After 141 years of existence as a society of physicians, dedicated to serving the needs of the people of Wisconsin, I will continue that great tradition as your new president. From Doctor Darling to Doctor Kempthorne, much has changed in the practice of medicine. However, the basic relationship between the doctor and his patient will continue unchanged from now until we no longer exist. I believe the close, warm and helpful doctor-patient relationship can and will prevail in our present complicated medical environment.

When I testified before a subcommittee of the United States Senate, chaired by Senator Kasten, on behalf of the State Medical Society, I concluded my comments on the Federal Trade Commission's active intrusion into the learned professions as follows:

> *Regardless of the rulings, we do not and have not approached our chosen discipline on other than a professional basis. Medicine is not a factory. We believe that neither the Wisconsin nor the American public wants factory medicine which would destroy the individual relationship between the doctor and the patient. The public also has a right to have that relationship subject to peer review without unnecessary time-consuming and restrictive federal regulations which serve only to hinder the flow of quality care. As licensed physicians, there are standards to be met which are appropriate and necessary. The profession of medicine requires that the care provided be subject to review by the peers in that profession without being subjected to confusing, overly complicated, and uncertain regulation which only delays quality care and makes it more expensive.*

In the role of President of this great organization, I will strive to serve as your ambassador of good will. I intend to tell everyone of our dedication and service. I hope to help reverse the headlines from the few bad eggs to the great and good accomplishments of this profession. For in no other profession is there such a special relationship between the professional and the person he serves than in our traditional, intimate doctor-patient relationship. I only ask that you continue to exemplify that tradition and heritage in your life's work—so I can proudly go about the State of Wisconsin spreading the good word.

"In my role of President of this great organization, I will strive to serve as your ambassador of good will. I intend to tell everyone of our dedication and service."

Henry David Thoreau in *Walden* expressed:

I went to the woods because I wished to live deliberately, to front only the essential facts of life, and see if I could not learn what it had to teach, and not, when I came to die, discover that I had not lived. ■

Past President Motzel...

Report to the House of Delegates as President

As I RISE TO SPEAK before you today, it is with mixed feelings—certainly I share the feeling of relief that must be common to past presidents. It is difficult, probably impossible, to anticipate the demands of this office on one's time. In these days of social activism it is essential that physicians through their societies expand their political and liaison activities with legislators, with state and federal agencies, business, labor, and other professional groups. These activities in turn reemphasize the State Medical Society's need to maintain and increase internal contact with county societies and individual members throughout the State. If your elected officers—that is, the physicians involved—are to be other than mere figure heads—and I believe they must be—much of this communication must be their responsibility. While these tasks are challenging, interesting and informative, they still compete heavily with family obligations and private practice. My other feeling, however, is somewhat nostalgic—I only realized a few days ago that you as a body have had to tolerate me up here for eight years, so you too deserve to feel relief—probably much more than I.

Will we accomplish this utilization review voluntarily, or will we accomplish it only competitively?

But to the business at hand—

When faced with the task of reviewing the accomplishments of the State Medical Society over the past 14 months, it very quickly becomes apparent that those accomplishments are attributable to an overwhelming degree to the enormous amount of work carried out by the dedicated staff of the Society. For this much credit must go to Earl Thayer, whose diligent selection and continuing supervision and example have fashioned a group whose development and assessment of information, whose advice and preparation of materials, and whose ability to carry out the decisions of the various committees and the Board of Directors is surely unmatched by any other society.

But having extolled the staff honestly and without exaggeration, it is also true that that staff is useless and extravagant without the participation—not *just* membership—but without real participation in the discussion of issues, in committee activity, in decision-making, in setting of policy, and in continuing political activity—by each and every one of you, and by all physicians in Wisconsin. And here, too, in our many committees and commissions a great many physicians have given selflessly of their time and expertise—I would cite a few who deserve special recognition: Your president-elect, Doctor Kempthorne, who has helped me immeasurably by meeting with county societies and representing us in testimony at Senate hearings dealing with the FTC in Washington, DC, and again in meeting with the Commissioner ten days ago in Milwaukee—this in addition to his great dedication to and accomplishments in the area of peer review and the Impaired Physician Program; Doctor Lewis, past president, who has continued to serve so well in our meetings with business and industry; Dr Ken Viste who has put in long hours with the work of the Physicians Alliance; Dr J D Kabler who has ably assumed the duties previously so well performed by Dr Joseph Lubitz as chairman of the Governmental Affairs Commission; Dr Russell Quirk whose Medical Liability Committee has served the Society so well—and the many others who are equally deserving.

But on to our review—

In March 1981 we suggested some goals for the ensuing year—how have those goals faired?

In membership we have done well, although we've fallen far short of 100 percent. As many predicted, a fair number of those who would not join unless unified membership was abolished have had to scurry for other cover in order to avoid the responsibilities of organized medicine—it is problematic whether those physicians can ever be made to understand their responsibility—we need to continue to try—but there are other nonmembers who are simply waiting to be asked—*let's ask them to join.* Membership is everyone's responsibility.

Communications with business and industrial leaders—initiated by Doctor Lewis, is an area in which real progress has been achieved, but again an area in which much remains to be done. We have met with leaders from Superior, Eau Claire, Wausau, and communities in the Fox River Valley, while local physicians have met with representatives of industry in other areas of the state. It is critical that these meetings continue and spread, for the depth

Presented before the House of Delegates of the State Medical Society of Wisconsin at its Annual Meeting, May 13-15, 1982, in Milwaukee.
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of misunderstanding between us and our potential business allies is great; and if it remains as it is today, the overwhelming pressure to reduce medical cost will be unnecessarily badly misdirected to the detriment of the medical care of large numbers of the general public—our patients. Indeed, these communications have been carried to unions as well. We have had rewarding conversations with the Wisconsin Education Association in such areas as consumer education, health care benefit insurance program design, and peer and utlilization review. Continuing constructive meetings have been arranged with Wisconsin Education Association leaders.

"In these days of social activism it is essential that physicians through their societies expand their political and liaison activities with legislators, with state and federal agencies, business, labor, and other professional groups."

In the area of better communication with the nursing profession and hospital administration we have made some beginnings. I look upon my personal appointment to the Committee to Revise the Wisconsin Hospital Administrative Code and to the Nursing Practice Committee, appointed by the State Health Policy Council, as opportunities for real communication between our professions. I believe that these expectations are being realized and that they may serve to increase our interaction between these groups. On a broader organizational plane, our Ad Hoc Committee on Health Practitioners has recommended—and your Board of Directors accepted—the formation of a formal liaison group with nursing representatives to deal with physician-nurse relationships in the hospital setting. Discussions are also under way with the Wisconsin Hospital Association to jointly sponsor a Conference on Cost Containment in Stevens Point on September 23 and 24 of this year.

Our hope to establish a closer working relationship with the Auxiliary has also been implemented at the state level with the president and president-elect of the Auxiliary present at Executive Committee meetings. This has proved very successful as a means of direct communication and in addition has generated some mutually advantageous ideas. Several county societies have implemented similar arrangements with excellent results. In addition, several auxilians have been appointed as members of State Medical Society committees in recent months. Again a continuing process.

In addition to these major goals, we predicted certain issues would require Society attention during the year, and indeed they have.

Areas of success include the chiropractic issues and the question of restructuring of the Department of Regulation and Licensing with emasculation of the Medical Examining Board. But while successful in this year, these are perennial issues which require eternal vigilance.

We have successfully encouraged the enactment of a mechanism of reporting significant hospital staff disciplinary action to the Medical Examining Board. A recent series of articles in the *Chicago Tribune* certainly demonstrates the value of such a process.

Less successful or continuing as unresolved problems are the issues of Medicaid and all its ramifications including uniform fee schedules, and problems with WHCLIP and liability insurance in general. These are continuing problems as are public health issues; and last but not least, the "second opinion program."

In other areas our delegation to the AMA has continued to develop leaders while maintaining its example of responsible expenditure in the face of some bizarre extravagance of other state delegations. In spite of this Doctor Collentine has been reelected to the AMA Council on Medical Service, and Doctor Twelmeyer has been appointed to chair a special committee of the House charged with exploring ways to reorganize the annual and interim meetings of the AMA for greater efficiency and to reduce costs without reducing participation in the democratic process. A herculean task worthy of Henry.

Closer to home, a very successful leadership conference was held last November at the Marriott in Brookfield. Discussions were open and frank. I'm certain many physician leaders from throughout the state left gratified and perhaps surprised at the honesty manifested in the recognition of problems within the House of Medicine and the determination of all the participants to work for their correction.

"It is apparent that many physicians are coming to realize that there are a few critical issues around which much, if not most, of our activity revolves—these issues are the cost and quality of medical care."

Partially from this conference, but also as a result of meeting with groups and individual physicians around the state, it is apparent that many physicians are coming to realize that there are a few critical issues around which much, if not most, of our activity revolves—these issues are the *cost* and the *quality* of medical care. If these two issues are perceived as antithetical—as some do—the future seems grim, our problem is unsolvable, and we are doomed to a bitter delaying action as social and economic imperatives gradually overwhelm us.

"As I've met with business and industrial leaders in Wisconsin . . . I can only conclude that the amount of money that society is willing to pay for medical care of all kinds today is less than the cost of the product they want and expect."

I, for one, do not believe cost and quality are antithetical. I really believe that cost is *one* element of the quality of medical care, albeit an important one, and a critical one in our time. It is with a few observations in this area that I would end these remarks and my term of office.

As I've met with business and industrial leaders in Wisconsin or attended similar national meetings, as I've seen the budgetary problems of government programs, as I've listened to individual patients and insurance representatives—I can only conclude that the amount of money that society is willing to pay for medical care of all kinds today is less than the cost of the product they want and expect. In *some* degree that disparity exists because of inefficiency and waste in the delivery of care—*some* of this is the direct responsibility of us—of physicians. This is our problem—collectively and individually—*some* is the responsibility of patients, frequently encouraged by insurance contracts and government programs—this is *partially* our problem and we must work with other parties involved who frequently are not able to see or easily understand their part in correcting costly patient abuse.

Finally, when all possible inefficiency and abuse are eliminated, there may well be left more "desired product" than perceived available money to pay for that product. It will then fall to the medical profession to *participate* in discussions that deal with social decisions to either increase the amount of the Gross National Product spent on health care, or limit the amount and character of health care available—rationing.

This latter is a global issue that we had better begin to think about—the former is an immediate issue that we had better accept and begin *yesterday.*

This is the inescapable issue of honest, fair, local, but difficult utilization review—stripped of the time-worn "dodge" that it *must* impair quality. If carried out with diligence by physicians, it can and will be an element of quality. It will change some of our cherished habits—with difficulty, to be sure—but some which we probably need to shed for the *greater* good of making possible the widest distribution of excellent medical care in our society without restriction (rationing).

In this respect the ball is in our court. Can we, will we accomplish this utilization review voluntarily, or will we accomplish it only competitively in the HMO setting with its dangers to patient care as future managers of these organizations perceive that profit and competition demand that the patient receive ever less quality service?

A final difficult issue: that of physician fees—

First, I believe—and incidentally I think most—not all, but most of those sometimes perceived as our adversaries also believe that physicians deserve adequate financial remuneration in keeping with years of training, hours worked, stress, risk, and the like. But having said this, there remain fees that cannot be justified by any of the above. They have frequently come about as new and developing procedures were introduced. But with the development of new instrumentation and refinement and standardization of techniques, appropriate readjustments have not occurred. Unfortunately, the ability of the profession in general to insist on rectification of these fees has been hampered by bureaucrats, largely in the Federal Trade Commission. Perhaps we have welcomed this excuse to avoid a difficult internal issue, but I believe the time has come when we need to aggressively seek ways to address this issue for the very same reasons that we must achieve utilization review.

These are tough issues and an uncomfortable note on which to end. Nevertheless, we are gathered here today as the elected leaders of organized medicine in Wisconsin. Our response to these issues will determine whether we are really worthy of that trust. ■

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SMS SERVICES INC.

SMS Services, Inc.

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SMS Services, Inc.

PROGRAMS ADMINISTERED BY SMS SERVICES:

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- SEMINARS
- PRINT SHOP
- UNIFORM CLAIM FORMS

ENDORSED DISCOUNT PROGRAMS:

- AUTO LEASING—Lease Associates
- AUTO RENTAL—Avis
- DEBT COLLECTION—I.C. Systems
- FURNITURE PURCHASE—office, waiting, and examining room—M&M Furniture
- BOOKS—Brown's Book Store
- GROUP TOURS

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New Fifty-Year Club members—1982

FIFTY-YEAR CLUB MEMBERS in attendance at the Annual Dinner of the 1982 Annual Meeting of the State Medical Society are shown above after receiving their awards. Front row, left to right: Nathan Slutsky, MD, Milwaukee; James H Biller, MD, Milwaukee; Charles R Brillman, MD, Milwaukee; Paul E Campbell, MD, Waukesha; Milton J Donkle, MD, Edgerton; James J Barrock, MD, Elm Grove; Walter A Gramowski, MD, Stevens Point; E Frank Castaldo, MD, Laona. Back row, left to right: President Albert J Motzel Jr, MD, Waukesha; Raymond J Rogers, MD, Oconto; Clement F Cheli, MD, Columbus; N W McKittrick, MD, Milwaukee; Hyman A Gantz, MD, Waukesha; Arthur A Holbrook, MD, Milwaukee; Lynn J Seward, MD, Berlin; Erwin P Ludwig, MD, Wild Rose; Benjamin H Brunkow, MD, Monroe; and Max O Bachhuber, MD, Alma.

Others who were inducted into the Fifty-Year Club are: Alois M Bachhuber, MD, Kaukauna; Arthur C Bachus, MD, Green Valley, Arizona; Lester J Bayer, MD, Merrill; Desmond H Callaghan, MD, Hayward; Samuel L Chase, MD, Madison; Clifford M Creswell, MD, Kenosha; Gwilym Davies, MD, Waukesha; Stephen F De Fazio, MD, Kenosha; William F Donlin, MD, Belleville; Harold H Fechtner, MD, Greenfield; Lawrence L Garner, MD, La Jolla, California; Esther W Goldberger, MD, Milwaukee; Jerome M Jekel, MD, Naples, Florida; William J Kleis, MD, Wauwatosa; William F Konnak, MD, Racine; Clement L Lacke, MD, Madison; Paul B Mason, MD, Sheboygan; Cecil A Morrow, MD, Kenosha; Michael S Nefches, MD, Largo, Florida; Frank J Pallasch, MD, Milwaukee; Gordon W Petersen, MD, Milwaukee; Kenneth G Pinegar, MD, Marinette; Cyril J Radl, MD, Manitowoc; Maurice G Rice, MD, Stevens Point; H C Schmallenberg, MD, New London; Edgar A Schoenecker, MD, Milwaukee; Herman H Shapiro, MD, Madison; Robert L Waffle, MD, Fond du Lac; George H Wegmann, MD, Wauwatosa; and David J Werner, MD, Milwaukee. (Staff photo by Neal Neuberger)■

BOARD DISTRICTS AND DIRECTORS

District — Director

1—John P Mullooly, MD, Milwaukee
Jerome W Fons Jr, MD, Cudahy
Carl S Eisenberg, MD, Milwaukee
Wayne H Konetzki, MD, Waukesha
Wayne J Boulanger, MD, Milwaukee
Fredrick Wood Jr, MD, Kenosha
William A Nielsen, MD, West Bend
Irwin J Bruhn, MD, Walworth
Thomas A Hofbauer, MD, Menomonee Falls
William L Treacy, MD, Milwaukee

2—J D Kabler, MD, Madison
James J Tydrich, MD, Richland Center
William P Crowley Jr, MD, Madison
Allen O Tuftee, MD, Beloit
Cyril M Hetsko, MD, Madison

3—Pauline M Jackson, MD, LaCrosse

4—John J Kief, MD, Rhinelander
Jung K Park, MD, Wisconsin Rapids

5—Darold A Treffert, MD, Fond du Lac
Timothy T Flaherty, MD, Neenah

6—Roger L von Heimburg, MD, Green Bay
Irvin L Schroeder, MD, Plymouth

7—Paul S Haskins, MD, River Falls

8—Joseph M Jauquet, MD, Ashland

SMS Placement Service aids physicians and communities

ONE OF THE MANY FUNCTIONS of the State Medical Society of Wisconsin is to assist physicians who are seeking a location to practice in Wisconsin and to assist communities seeking the services of physicians.

The Society's Placement Service maintains a continuous listing of names and biographical data on physicians who wish to locate in Wisconsin. Files are maintained on communities desiring physicians. Information is exchanged with interested physicians and communities, with the American Medical Association, and with the two Wisconsin medical schools. There is no charge to either physician or community for this service.

A list of openings is sent to physicians who contact Placement Service indicating a desire to locate in Wisconsin or to relocate within the state. A list of physicians is sent to communities requesting assistance in obtaining a physician. The physicians and communities may then contact one another. Physicians seeking associates also may request a listing of available physicians.

Experience of Placement Service shows that physicians seek locations on a long-range basis—some are available at once, while others are in residency for two or three years. One word of advice: Advise the Society's Placement Service of your needs as soon as possible. Overnight results occur but more time usually means better results.

It should be noted that Placement Service is not a recruiting effort. Its function is supported by membership in the State Medical Society of Wisconsin. The Society does, however, cooperate with the state-supported Office of Rural Health in its New Physicians for Wisconsin Program which provides placement services to communities and physicians on a fee basis determined by budgetary funds available.

Physicians and communities also may utilize the "Medical Yellow Pages" section of the *Wisconsin Medical Journal.* This classified advertising section is available to members of the State Medical Society, other physicians, communities, clinics, hospitals, recruitment firms, and others at reasonable rates.

Physicians using the Placement Service have described it as one of the most effective in the United States. *Journal* advertising, too, has proved highly successful.

Inquiries should be addressed to Placement Service, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701; tel 608/257-6781; and/or *Wisconsin Medical Journal,* Box 1109, Madison, Wis 53701. ■

OFFICERS AND DIRECTORS: 1982-1983

STATE MEDICAL SOCIETY OF WISCONSIN
330 East Lakeside St (PO Box 1109), Madison, Wisconsin 53701
Telephone: 608/257-6781 (toll-free in Wisconsin 1-800-362-9080)

Officers of the Society

President (1982-1983)
Gerald C Kempthorne, MD, 153 E Jefferson, Spring Green 53588

President-elect (1982-1983)
Chesley P Erwin, MD, 8700 W Wisconsin Ave, Milwaukee 53226

Secretary/General Manager (1982-1983)
Earl R Thayer, 330 East Lakeside St, Madison 53701

Treasurer (1982-1983)
John J Foley, MD, PO Box 427, Menomonee Falls 53051

Board of Directors

Chairman: *Darold A Treffert, MD*
Vice Chairman: *Timothy T Flaherty, MD*

Directors (by districts*)

FIRST: Kenosha, Milwaukee, Ozaukee, Racine, Walworth, Washington, Waukesha Counties

John P Mullooly, MD 1982-1985): 8430 W Capitol Dr, Milwaukee 53222
Jerome W Fons Jr, MD (1982-1985): 3533 E Ramsey Ave, Cudahy 53110
Carl S Eisenberg, MD (1980-1983): PO Box 17300, Milwaukee 53217
Wayne J Boulanger, MD (1981-1984): 2015 E Newport, Milwaukee 53211
Thomas A Hofbauer, MD (1981-1984): PO Box 427, Menomonee Falls 53051
Wayne H Konetzki, MD (1981-1984): 403 N Grand Ave, Waukesha 53186
William A Nielsen, MD (1981-1984): 217 S 17th Ave, West Bend 53095
Irwin J Bruhn, MD (1981-1984): Rt 1, Lakeville Rd, Walworth 53184
Fredrick Wood Jr, MD (1981-1984): 6530 Sheridan Rd, Kenosha 53140
William L Treacy, MD (1981-1984): 10125 W North Ave, Milwaukee 53226

SECOND: Adams, Columbia, Dane, Dodge, Grant, Green, Iowa, Jefferson, Lafayette, Marquette, Richland, Rock, Sauk Counties

J D Kabler, MD (1982-1985): 1552 University Ave, Madison 53706
Cyril M Hetsko, MD (1982-1985): 1313 Fish Hatchery Rd, Madison 53715
James J Tydrich, MD (1982-1985): 1313 W Seminary St, Richland Center 53581
Allen O Tuftee, MD (1982-1985): 1905 Huebbe Parkway, Beloit 53511
William P Crowley Jr, MD (1981-1984): 20 S Park St, Madison 53715

THIRD: Buffalo, Crawford, Jackson, Juneau, La Crosse, Monroe, Trempealeau, Vernon Counties

Pauline M Jackson, MD (1980-1983): 1836 South Ave, La Crosse 54601

FOURTH: Clark, Florence, Forest, Langlade, Lincoln, Marathon, Oneida, Portage, Price, Taylor, Vilas, Wood Counties

John J Kief, MD (1980-1983): 1020 Kabel Ave, Rhinelander 54501
Jung K Park, MD (1982-1985): 410 Dewey St, Wisconsin Rapids 54494

FIFTH: Calumet, Fond du Lac, Green Lake, Outagamie, Waupaca, Waushara, Winnebago Counties

Darold A Treffert, MD (1982-1985): 459 E First St, Fond du Lac 54935
Timothy T Flaherty, MD (1980-1983): 547 E Wisconsin Ave, Neenah 54956

SIXTH: Brown, Door, Kewaunee, Manitowoc, Marinette, Menominee, Oconto, Shawano, Sheboygan Counties

Roger L von Heimburg, MD (1980-1983): 900 S Webster, Green Bay 54301
Irvin L Schroeder, MD (1982-1985): 210 Selma St, Plymouth 53073

SEVENTH: Barron, Chippewa, Dunn, Eau Claire, Pepin, Pierce, Polk, Rusk, St Croix, Burnett, Washburn Counties

Paul S Haskins, MD (1980-1983): 409 Spruce St, River Falls 54022

EIGHTH: Ashland, Bayfield, Douglas, Iron, Sawyer Counties

Joseph M Jauquet, MD (1981-1984): 200 7th Ave West, Ashland 54806

* * *

PRESIDENT: *Gerald C Kempthorne, MD* (1982-1983), 153 E Jefferson, Spring Green 53588
PRESIDENT-ELECT: *Chesley P Erwin, MD* (1982-1983), 8700 W Wisconsin Ave, Milwaukee 53226
PAST PRESIDENT: *Albert J Motzel Jr, MD* (1982-1983), 1111 Delafield St, Waukesha 53186
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VICE SPEAKER: *Vernon M Griffin, MD* (1982-1984), 767 Elm St, Mauston 53948

Ex officio, without vote
Secretary *Thayer,* Treasurer *Foley*

*Map indicating location of districts appears on opposite page.

NOTE: Officers, directors, delegates, alternate delegates, and members of commissions and committees are elected at the Annual Meeting (May 1982). Dates in parentheses indicate beginning and expiration of term of office. AMA delegates and alternate delegates' terms of office are on a calendar basis, although elected at the Annual Meeting.

Delegates to the American Medical Association

DeLore Williams, MD (1982-83-84), 8501 W Lincoln Ave, West Allis 53227
Patricia J Stuff, MD (1982-83-84), PO Box 366, Bonduel 54107
John K Scott, MD (1982-83-84), 1 South Park St, Madison 53715
Henry F Twelmeyer, MD (1982-1983), 2500 N Mayfair Rd, Wauwatosa 53226
Richard W Edwards, MD (1982-1983), 1313 W Seminary St, Richland Center 53581

Alternate Delegates to the AMA

John D Riesch, MD (1982-83-84), PO Box 427, Menomonee Falls 53051
Cornelius A Natoli, MD (1982-83-84), 2760 Hagen Rd, La Crosse 54601
J D Kabler, MD (1982-1983), 1552 University Ave, Madison 53706
Kenneth M Viste Jr, MD (1982-1983), 100 Stoney Beach Rd, Oshkosh 54901
Walter J Woloschek, MD (1982-83-84), 2500 N Mayfair Rd, Milwaukee 53226■

BOARD OF DIRECTORS COMMITTEES:* 1982-83

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President of the Society
Chesley P Erwin, MD, Milwaukee
President-elect of the Society
Albert J Motzel Jr, MD, Waukesha
Immediate Past President of the Society
Darold A Treffert, MD, Fond du Lac
Chairman of the Board
Timothy T Flaherty, MD, Neenah
Vice Chairman of the Board
Duane W Taebel, MD, LaCrosse
Speaker of the House of Delegates
William A Nielsen, MD, West Bend
Chairman, Finance Committee
Roger L von Heimburg, MD, Green Bay
EX OFFICIO nonvoting members
President and President-elect of SMS Auxiliary

Finance Committee of the Board

William A Nielsen, MD, West Bend, 1984
Chairman
Joseph M Jauquet, MD, Ashland, 1984
Wayne J Boulanger, MD, Milwaukee, 1983
Cyril M Hetsko, MD, Madison, 1982
Jung K Park, MD, Wisconsin Rapids, 1982
Irvin L Schroeder, MD, Plymouth, 1982
John J Foley, MD, Menomonee Falls
Treasurer, ex officio

*Subject to review and possible additions or changes in July 1982.■

SMS AUXILIARY: 1982-83

ELECTED OFFICERS

President: Mrs Leonard B Torkelson, 1380 Franklin Street, Baldwin 54002
President-elect: Mrs K Alan Stormo, 270 Sheboygan Street, Fond du Lac 54935
Vice President: Mrs Stephen B Webster, 2250 Wedgewood Drive, La Crosse 54601
Recording Secretary: Mrs Charles Longstreth, Route 1, Box 163J, Maple Ridge Road, Ashland 54806
Treasurer: Mrs Charles Yale, 209 Farwell Drive, Madison 53704
Immediate Past President: Mrs Donald A Peterson, 1101 Merrill Springs Road, Madison 53705

DIRECTORS

East Central: Mrs Donald Gore, 2528 North Third Street, Sheboygan 53081
West Central: Mrs Patrick Macken, Route 3, Elderberry Lane, Eau Claire 54701
Northeast: Mrs Gerald Gehl, 210 Elm Street, Neenah 54956
Northwest: Mrs Roger Branham, RFD 2, Box 52-3, Rice Lake 54868
Southeast: Mrs Roger C Baldwin, 119 Concord Avenue, Watertown 53094
Southwest: Mrs C A Natoli, 2760 Hagen Road, La Crosse 54601

APPOINTED OFFICERS

Parliamentarian: Mrs Robert E Johnston, 3825 Waubenoor Drive, Green Bay 54301
Historian: Mrs C M Scott, 11 St Alban's Road, Superior 54880

EXECUTIVE SECRETARY

Mrs LaVerne Bartel, 330 East Lakeside Street, Madison 53715■

RELATED ORGANIZATION BOARDS: 1982-83

SMS Realty Corporation *Trustees*

Eugene J Nordby MD, Madison, 1984, *President*
Richard W Edwards MD, Richland Center, 1985, *Vice President*
John J Foley MD, Menomonee Falls, 1983, *Treasurer*

SMS Services, Inc *Directors*

William P Crowley Jr MD, Madison, 1983, *President*
John P Mullooly MD, Milwaukee, 1984, *Vice President*
Richard W Edwards MD, Richland Center, 1982, *Treasurer*
Earl R Thayer, Madison, 1984, *Secretary*
Timothy T Flaherty MD, Neenah, 1982
A James Bennett MD, Kenosha, 1985
Jerome W Fons Jr MD, Cudahy, 1983
Allen O Tuftee MD, Beloit, 1983
John J Foley MD, Menomonee Falls, 1984

Special Officers

H B Maroney II, Madison, *Assistant Secretary*
LeRoy A Johnson, Madison, *Executive Vice President*

Charitable, Educational and Scientific Foundation

(See listing elsewhere in this issue)■

PAST PRESIDENTS OF THE STATE MEDICAL SOCIETY OF WISCONSIN: 1953-1982

This is a partial listing. The complete listing from 1841 to 1972 appeared in the January 1973 issue.

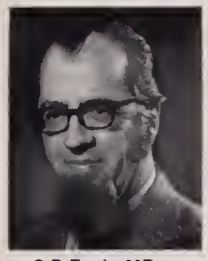
H Kent Tenney, MD, Madison 1953-1954
†Arthur J McCarey, MD, Green Bay 1954-1955
†Ervin L Bernhart, MD, Milwaukee 1955-1956
†L Otis Simenstad, MD, Osceola 1956-1957
†Harry E Kasten, MD, Beloit 1957-1958
†Jerome W Fons, MD, Milwaukee 1958
†William B Hildebrand, MD, Menasha 1959-1960
Edmund D Sorenson, MD, Elkhorn 1960-1961
Leif H Lokvam, MD, Kenosha 1961-1962
Nels A Hill, MD, Madison 1962-1963
†William J Egan, MD, Milwaukee 1963-1964
William P Curran, MD, Antigo 1964-1965
†John H Houghton, MD, Wisconsin Dells 1965-1966
†Frank E Drew, MD, Milwaukee 1966-1967
Harold J Kief, MD, Fond du Lac 1967-1968
†William D James, MD, Oconomowoc 1968-1969
Robert E Callan, MD, Milwaukee 1969-1970
Jerry W McRoberts, MD, Sheboygan 1970-1971
George A Behnke, MD, Kaukauna 1971-1972
Robert F Purtell, MD, Milwaukee 1972-1973
Gerald J Derus, MD, Madison 1973-1974
John E Dettmann, MD, Green Bay 1974-1975
Howard L Correll, MD, Arena 1975-1976
Charles J Picard, MD, Superior 1976-1977
Roy B Larsen, MD, Wausau 1977-1978
Jules D Levin, MD, Milwaukee 1978-1979
Darold A Treffert, MD, Fond du Lac 1979-1980
Russell F Lewis, MD, Marshfield 1980-1981
Albert J Motzel Jr, MD, Waukesha ..... 1981-1982■

†Deceased

OFFICERS AND DIRECTORS: 1982-1983

STATE MEDICAL SOCIETY OF WISCONSIN

G C Kempthorne MD
President



C P Erwin MD
President-elect

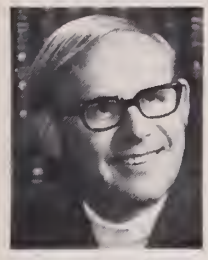
E R Thayer
Secretary

J J Foley MD
Treasurer

A J Motzel Jr MD
Past President

D W Taebel MD
Speaker

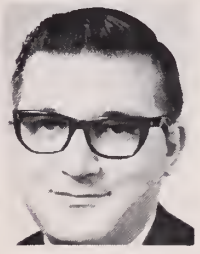
V M Griffin MD
Vice Speaker



D A Treffert MD
Board Chairman
Director, Dist 5

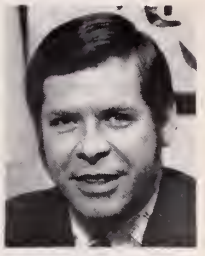
T T Flaherty MD
Board V-Chairman
Director, Dist 5

W J Boulanger MD
Director, Dist 1



J P Mullooly MD
Director, Dist 1

J W Fons Jr MD
Director, Dist 1



T A Hofbauer MD
Director, Dist 1

C S Eisenberg MD
Director, Dist 1

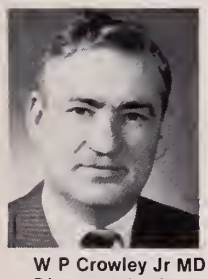
W H Konetzki MD
Director, Dist 1

W A Nielsen MD
Director, Dist 1

I J Bruhn MD
Director, Dist 1

F Wood Jr MD
Director, Dist 1

W L Treacy MD
Director, Dist 1



W P Crowley Jr MD
Director, Dist 2

A O Tuftee MD
Director, Dist 2

C M Hetsko MD
Director, Dist 2

J D Kabler MD
Director, Dist 2

J J Tydrich MD
Director, Dist 2

P M Jackson MD
Director, Dist 3

J J Kief MD
Director, Dist 4

J K Park MD
Director, Dist 4

R L von Heimburg MD
Director, Dist 6

I L Schroeder MD
Director, Dist 6

P S Haskins MD
Director, Dist 7

J M Jauquet MD
Director, Dist 8

COMMISSIONS AND COMMITTEES: 1982-1983

STATE MEDICAL SOCIETY OF WISCONSIN
330 East Lakeside St (PO Box 1109), Madison, Wisconsin 53701
Telephone: 608/257-6781 (toll-free in Wisconsin 1-800-362-9080)

COMMISSIONS

Continuing Medical Education

This commission shall consist of nine appointed members and the deans of the two medical schools in Wisconsin, with vote. It shall be responsible for all matters relating to the whole continuum of medical education, i.e., medical school and residency training as well as lifetime medical learning (continuing medical education). In addition, it shall be responsible for liaison with the medical schools in Wisconsin, their students, residents, fellows and departments of continuing medical education; liaison with specialty societies in the achievement of these goals; liaison with the Commissions on Peer Review and Health Planning for purposes of implementing continuing medical education programs related to responsibilities and activities of these two commissions; and the scientific program of the Annual Meeting. It shall be responsible for accreditation of continuing medical education in hospitals and other institutions or organizations within the state, but shall not be responsible for accreditation of continuing medical education within the state's medical schools.

Frank E Berridge, MD, Milwaukee, 1983
Martin Z Fruchtman, MD, Waukesha, 1983
John J Koch, MD, Prairie du Sac, 1983
Joseph J Mazza, MD, Marshfield, 1983
James T Houlihan, MD, Woodruff, 1984
Charles L Junkerman, MD, Milwaukee, 1984
John L Raschbacher, MD, Waukesha, 1984
Leonard H Wurman, MD, Wausau, 1984
C William Freeby, MD, Appleton, 1985
Bradley G Garber, MD, Osseo, 1985
Kenneth I Gold, MD, Beloit, 1985
Edwin L Overholt, MD, La Crosse, 1985
Thomas P Simerson, MD, Merrill, 1985
Dean Arnold L Brown, MD, Madison
University of Wisconsin Medical School
Dean Edward J Lennon, MD, Milwaukee
Medical College of Wisconsin

CME COMMITTEE

Subcommittee on Accreditation

Bradley G Garber, MD, Osseo
Richard D Sautter, MD, Marshfield
Leonard H Wurman, MD, Wausau
Melvin F Huth, MD, Baraboo
Warren J Holtey, MD, Marshfield
Joseph J Mazza, MD, Marshfield
Jerold J Beerends, MD, West Bend
Eugene Musser, MD, Madison
Paul R Glunz, MD, Beaver Dam
Sherman P Vinograd, MD, Madison

Governmental Affairs

This commission shall concern itself with all state and federal health legislation, its analysis and communication to the membership; preparing and securing state or federal health legislation for the best interests of the public, scientific medicine, and the medical profession; legislative representation and liaison, state and federal; informing the membership of the Society of important proposed legislation and encouraging members to be active individually in political affairs; liaison between the Society and executive and legislative branches of government.

Membership of the Commission on Governmental Affairs shall include a representative from each of the specialty sections of the Society. These representatives shall be appointed by the specialty sections annually. Such appointments shall be subject to the approval by the Board of Directors. Representatives on the Commission from the specialty sections need not be counted for purposes of a quorum for a meeting of the Commission on Governmental Affairs, but shall have the right to vote.

Jack D Edson, MD, Eau Claire, 1983
Robert F Purtell Jr, MD, Milwaukee, 1983
Raymond C Zastrow, MD, Wauwatosa, 1983
Gerald A Gehl, MD, Neenah, 1984
Martin L Janssen, MD, Friendship, 1984
William J Maurer, MD, Marshfield, 1984
Thomas P Belson, MD, Waukesha, 1985
JD Kabler, MD, Madison, 1985
Geoffrey Kloster, MD, Merrill, 1985

SECTION REPRESENTATIVES

Allergy & Immunology: *James R Mattson, MD,* Green Bay
Anesthesiology: *John F Kreul, MD,* Madison
Dermatology:
Emergency Medicine: *Mark Olsky, MD,* Madison
Family Physicians: *Patrick W Connerly, MD,* Eau Claire
Internal Medicine: *Michael P Mehr, MD,* Marshfield
Medical Faculties:
Neurology: *Henry A Peters, MD,* Madison
Neurosurgery: *Alan B Levin, MD,* Madison
Obstetrics & Gynecology: *James B Torhorst, MD,* Madison
Ophthalmology: *M Thomas Chemotti, MD,* Cedarburg
Orthopedics: *Marvin W Nelson, MD,* Racine
Otolaryngology: *William W Finch, MD,* Madison
Pathology: *Harry J Zemel, MD,* Fond du Lac
Pediatrics: *Carl S Eisenberg, MD,* Milwaukee
Physical Medicine & Rehabilitation: *Neal Taylor, MD,* La Crosse
Plastic Surgery: *Vaughn Demergian, MD,* Madison
Psychiatry: *Darold A Treffert, MD,* Fond du Lac
Preventive Medicine: *Constantine Panagis, MD,* Milwaukee
Radiology: *Eugene H Betlach, MD,* Janesville
Residents:
Surgery: *George F Flynn, MD,* Milwaukee
Urology: *Raul F Waters, MD,* Madison

———

Medical Examining Board: *George M Daley, MD,* Milwaukee
SMS Auxiliary: *Anthony Sanfelippo,* Fond du Lac
EX OFFICIO (Board Chairman): *Darold A Treffert, MD,* Fond du Lac
SMS President: *Gerald C Kempthorne, MD,* Spring Green
SMS President-elect: *Chesley P Erwin, MD,* Milwaukee

GA COMMITTEE

Federal Legislation Committee

Robert F Purtell Jr, MD, Milwaukee, *Chairman*
Raymond C Zastrow, MD, Milwaukee

continued next page

Expiration of term at Annual Meeting of the year designated appears following member's name. Chairman and vice chairman of commissions and committees are elected at the first meeting following the Annual Meeting. The BLUE BOOK is prepared prior to most of these elections; therefore, some commissions and committees will not include these designations.

David R Weber, MD, Fond du Lac
Michael P Mehr, MD, Marshfield
Carl S Eisenberg, MD, Milwaukee
Roland R Liebenow, MD, Lake Mills
Robert L Johnson, MD, Wisconsin Rapids
Paul S Johnson, MD, Racine
DeLore Williams, MD, West Allis

Ex-Officio
J D Kabler, MD, Madison
Susan Eisenberg, Mequon

Health Planning

This commission shall be concerned about planning for health care, including facilities and services and their organization to assure availability, access and quality of care; standards, guidelines and regulations affecting health care; distribution of medical services; relationships with allied health personnel; and matters pertaining to the Joint Commission on Accreditation of Hospitals.

This commission also includes representatives of specialty sections/societies and chairmen of Physician HSA Task Forces with voting rights when present, provided they are SMS members, such appointments subject to approval by the Board of Directors.

Clarence R Hart, MD, Lake Geneva, 1983
Frederic L Hildebrand, MD, Neenah, 1983
Marvin G Parker, MD, Racine, 1983
Sigurd E Sivertson, MD, Madison, 1983
Peter L Eichman, MD, Madison
Jan E Erlandson, MD, Monroe
D Joseph Freeman, MD, Wausau, 1984
Guenther P Pohlmann, MD, Milwaukee, 1984
Lee M Tyne, MD, Brookfield, 1984
John B Davis, MD, Verona, 1985
Edward J Lennon, MD, Milwaukee, 1985
Kermit L Newcomer, MD, La Crosse, 1985
Bruce J Stoehr, MD, Green Bay, 1985
Michael E Tieman, MD, Berlin, 1985

SPECIALTY REPRESENTATIVES

Society
Allergy: *J Brent Kooistra, MD,* Madison
Family Physicians:
Internal Medicine: *Kenneth R Kubsch, MD,* Green Bay
Neurological: *Gamber F Tegtmeyer, MD,* Madison
Neurosurgical:
Obstetrics and Gynecology: *Norman J Schroeder, MD,* Beaver Dam
Pediatrics (Wisconsin Chapter): *Gary R Gutcher, MD,* Madison
Physical Medicine and Rehabilitation: *Albert M Cohen, MD,* Milwaukee
Preventive Medicine: *Richard W Biek, MD,* Milwaukee
Radiological: *Andrew B Crummy, MD,* Madison
Surgeons (Wisconsin Chapter): *John T Mendenhall, MD,* Madison
Surgical: *P Richard Sholl, MD,* Janesville

SMS Section
Anesthesiology: *Ann Bardeen Henschel, MD,* Oconomowoc
Dermatology: *Hal Ridgway, MD,* Madison
Emergency Medicine: *Thomas A Reminga, MD,* Milwaukee
Ophthalmology: *James C Allen, MD,* Madison
Otolaryngology: *Timothy J Donovan, MD,* Madison
Pathology: *Robert E Carlovsky, MD,* Fond du Lac
Physical Medicine and Rehabilitation: *John L Melvin, MD,* Milwaukee
Radiology: *Marcia J S Richard, MD,* Milwaukee
Resident Physicians:

Mediation and Peer Review

This commission may have up to 25 members. It shall receive, investigate, and seek to resolve differences between physicians and patients or other complainants, or between physicians, on matters relating to quality of care, professional ethics, and fees. When necessary, it shall initiate disciplinary or other action as appropriate. It shall serve as the Society's advisory body to private or governmental organizations on matters affecting medical peer review including utilization review, appropriateness of care, fees, and quality assurance. It shall advise and consult with component societies on issues of peer review, mediation, ethics, and discipline in concert with members of the Board of Directors. It shall serve as the initial appellate body for peer review and mediation issues that are appealed from local committees of component societies. It shall coordinate the impaired physician program.

Robert T Cooney, MD, Portage, 1983
Edsel G Doreza, MD, Walworth, 1983
Melvin F Huth, MD, Baraboo, 1983
Charles E Koepp, MD, Marinette, 1983
Robert E Johnston, MD, Green Bay, 1983
D Mark Lochner, MD, Waupaca, 1983
Richard Logan, MD, Madison, 1983
Harry F Weisberg, MD, Milwaukee, 1983
David E Westgard, MD, La Crosse, 1983
Lloyd R Cotts, MD, Rice Lake, 1984
Sharon L Elias, MD, Milwaukee, 1984
Joseph B Grace, MD, Green Bay, 1984
James M Huffer, MD, Madison, 1984
Thomas F Jennings, MD, West Allis
John B McAndrews, MD, Oshkosh, 1984
Robert E Phillips, MD, Marshfield, 1984
William E Raduege, MD, Woodruff, 1984
John D Riesch, MD, Menomonee Falls, 1984
Albert H Adams, MD, Milwaukee, 1985
Domenick S Bruno, MD, Milwaukee, 1985
Ronald J Darling, MD, Waukesha, 1985
John A DeGiovanni, MD, Prairie du Sac, 1985
Richard W Edwards, MD, Richland Center, 1985
Charles S Geiger Jr, MD, West Bend, 1985
Leo R Grinney, MD, Racine, 1985
Michael R McCormick, MD, Waukesha, 1985

MPR COMMITTEES

Coordinating Council on Physician Impairment
Gerald C Kempthorne, MD, Spring Green
John B McAndrew, MD, Oshkosh
Harry F Weisberg, MD, Milwaukee
(State Medical Society)
Ms Gwen Jackson, Milwaukee
Walter L Washburn, MD, Madison
Susan F Behrens, MD, Beloit
(Medical Examining Board)

Managing Committee, Statewide Impaired Physician Program
Roland E Herrington, MD, Milwaukee
Gerald C Kempthorne, MD, Spring Green
Fred H Koenecke Jr, MD, Madison
Arthur G Norris, MD, Milwaukee
Bela Maroti, Milwaukee
John C LaBissoniere, Madison

Medicaid Medical Audit Committee
John A DeGiovanni, MD, Prairie du Sac
Richard W Edwards, MD, Richland Center
Leo R Grinney, MD, Racine

continued next page

Gerald C Kempthorne, MD, Spring Green
John J Kief, MD, Rhinelander
D Mark Lochner, MD, Waupaca
Richard Logan, MD, Middleton
Virgil L Sharp, DO, Waterloo
G John Weir Jr, MD, Marshfield
David E Westgard, MD, LaCrosse
Alfred D Dally, MD, Madison

Physicians Alliance

This commission shall have 18 members consisting of one for each Society District, except that District 2 shall have two members and District 1 shall have seven members. In addition the President of the State Medical Society, the Chairman of the Board of Directors, and Chairman of the Commission on Governmental Affairs will be ex officio members with vote. Nominations for membership on the commission shall be made by the Board Nominating Committee, but nominees shall be actively solicited from within each district by contact with the county medical societies and the medical staffs of hospitals. The commission shall be concerned with planning, organizing, and implementing appropriate programs to protect, promote, and achieve the socio-economic interests of the members of the State Medical Society of Wisconsin. It shall report to the Board at every regular meeting and annually to the House of Delegates, both as to its operations and policy recommendations.

Jordon Frank, MD, Beloit, 1983
LaVern H Herman, MD, Waukesha, 1983
Jack M Lockhart, MD, La Crosse, 1983
Charles E Pechous Jr, MD, Kenosha, 1983
W Gregory Von Roenn, MD, Milwaukee, 1983
Thomas G Dehn, MD, Milwaukee, 1984
Joseph C Diraimondo, MD, Manitowoc, 1984
C Robert Jackson, MD, Madison, 1984
Dennis J Kontra, Racine, 1984
Richard Stone, MD, Milwaukee, 1984
John C Oujiri, MD, Ashland, 1985
William J Listwan, MD, West Bend, 1985
John O Simenstad, MD, Osceola, 1985
John E Thompson, MD, Nekoosa, 1985
Kenneth M Viste Jr, MD, Oshkosh, 1985

Ex officio voting members:
President, State Medical Society
Chairman of the Board of Directors
Chairman, Commission on Governmental Affairs

SPECIALTY REPRESENTATIVES

Allergy Society and Section: *Robert J Kriz, MD,* Madison
Anesthesiology Section: *George L Bush, MD,* Madison
Dermatology Section: *Robert A McDonald, MD,* Madison
Family Physicians Section: *Charles L Steidinger, MD,* Platteville
Medical Faculties Section: *Mark J Ciccantelli, MD,* Wauwatosa
Neurology Section: *Michael P McQuillen, MD,* Milwaukee
Neurosurgical Society and Section: *Allan B Levin, MD,* Madison
Obstetrics-Gynecology Section: *William J O'Leary, MD,* LaCrosse
Ophthalmology Section: *Edwin B Bercovici, MD,* Milwaukee
Resident Physicians Section:
Pediatrics Section: *Curtis R Weatherhogg, MD,* Madison
Physical Medicine and Rehabilitation Section:
Plastic Surgery Section: *Sidney K Wynn, MD,* Milwaukee
Preventive Medicine Section: *Richard W Biek, MD,* Milwaukee
Surgery Section:
Otolaryngological Society: *John E Clemons, MD,* LaCrosse
Pathology Society: *Dean M Connors, MD,* Madison
Psychiatry Society: *Robert F Goerke, MD,* Milwaukee
Urology Section: *Randle E Pollard, MD,* Milwaukee
Radiology Section: *Timothy T Flaherty, MD,* Neenah
Radiological Society: *Donald P Babbitt, MD,* Milwaukee
Dematological Society: *Derek J Cripps, MD,* Madison
Neurological Society: *Phiroze L Hansotia, MD,* Marshfield
Orthopedic Society: *Richard C Wixson, MD,* Madison
Pathology Section: *Kenneth A Stormo, MD,* Fond du Lac
Radiation Oncology Society: *John C Kirkpatrick, MD,* Madison
Neurosurgical Society: *Stephen M Cushman, MD,* Racine, or *Mohammed Raffiullah, MD,* Racine
Emergency Medicine Section: *John P Rahm, MD,* Madison
Surgical Society: *Russell P Sinaiko, MD,* Madison
Orthopedic Section: *Paul K Odlund, MD,* Janesville
American Academy of Pediatrics, Wisconsin Chapter: *Rolv Slungaard, MD,* LaCrosse
Obstetrics-Gynecology Society: *C Weir Horswill, MD,* Middleton
Surgical Society:

PAC COMMITTEES

Medical Liability Committee

Russell A Quirk, MD, Racine, *Chairman*
Norman O Becker, MD, Fond du Lac
Paul A Jacobs, MD, Milwaukee
Fred C Kriss, MD, Madison
Walter D Moritz, MD, Fort Atkinson
Eugene J Nordby, MD, Madison
William L Treacy, MD, Milwaukee
Thomas G Dehn, MD, Bayside
Vaughn Demergian, MD, Madison
Jung K Park, MD, Wisconsin Rapids

Cost Containment Committee

John O Simenstad, MD, Osceola, *Chairman*
Guenther P Pohlmann, MD, Milwaukee
Harry J Zemel, MD, Fond du Lac
Jeremy R Green, MD, Green Bay
William C Miller, MD, Wausau
Raymond R Johnson, MD, Ladysmith
James V Seegers, MD, Elkhorn
George C Owen, MD, Milwaukee
Frederick Wood, MD, Kenosha

Public Information

This commission shall be concerned about the members of this Society and their image with the public. It shall plan and execute programs of effective public information and health education, assist component societies in the conduct of similar programs, develop effective media relations, and recruit and retain physician members of the Society and encourage their active participation in the affairs of the county and state societies and the American Medical Association.

Joseph W Edgett Jr, MD, La Crosse, 1983
George L Gay Jr, MD, Cambridge, 1983
Mark J Popp, MD, Brookfield, 1983
Wallace MacMullen, MD, Green Bay, 1984
Carl R Poley, MD, Green Bay, 1984
Richard W Shropshire, MD, Madison, 1984
Robert J Goldberger, MD, Milwaukee, 1985
Stanley J Graiewski, MD, Oshkosh, 1985
Roland D Paegle, MD, Milwaukee, 1985
Charles Sorensen, MD, Wisconsin Rapids, 1985

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Wisconsin Medical Journal

The *Wisconsin Medical Journal* shall be the official journal of the Society. An editorial board consisting of the medical editor as chairman and six additional members shall be responsible for all scientific, editorial, and business affairs of the Journal. An editorial director, serving as chairman of a group of no less than five editorial associates, shall be responsible for regularly providing items of editorial opinion for publication in the editorial pages of the Journal.

EDITORIAL BOARD

Victor S Falk, MD, Edgerton, 1984
Chairman and *Medical Editor*
Dean M Connors, MD, Madison, 1983
Melvin F Huth, MD, Baraboo, 1983
M C F Lindert, MD, Milwaukee, 1984
Richard D Sautter, MD, Marshfield, 1984
Wayne J Boulanger, MD, Milwaukee, 1985
George W Kindschi, MD, Monroe, 1985
Garrett A Cooper, MD, Madison, Emeritus

EDITORIAL ASSOCIATES (appointed annually by Board of Directors)

Wayne J Boulanger, MD, Milwaukee
Chairman and *Editorial Director*
Victor S Falk, MD, Edgerton, *Medical Editor*
Russell F Lewis, MD, Marshfield
John P Mullooly, MD, Milwaukee
Raymond A McCormick, MD, Green Bay

* * *

COMMITTEES

Aging and Extended Care Facilities

This committee shall be concerned about the process of aging and means to achieve the best possible health care for the aged, including nursing home care.

Frederick W Blancke, MD, Madison, 1983
Jovan L Djokovic, MD, Janesville, 1983
Steven R Gambert, MD, Milwaukee, 1983—Chairman
Kay E Jewell, MD, Waupaca, 1983
Joseph C Springberg, MD, Beloit, 1983
Phillip M Green, MD, Marshfield, 1984
Terrence N Hart, MD, Brookfield, 1984
Richard J Hendricks, MD, Madison, 1984
Wilbur E Rosenkranz, MD, Mukwonago, 1984—V Chrmn
Edward R Winga, MD, La Crosse, 1984
Elston L Belknap Jr, MD, Madison, 1985
Donna D Davidoff, MD, Milwaukee, 1985
Edward L Perry, MD, La Crosse, 1985
Leslie H Stone, MD, Oshkosh, 1985
Roland R Liebenow, MD, Lake Mills, 1985
Mrs Charles (Moira) Desch, Waukesha, Auxiliary

Alcoholism and Other Drug Abuse

This committee shall be concerned about prevention, treatment, and rehabilitation for persons affected by alcoholism and any other type of drug abuse.

Dennis G Biros, MD, La Crosse, 1983
Michael C Gordon, MD, Janesville, 1983
Darold A Treffert, MD, Winnebago, 1983
Nunilo L Bugarin, MD, Tomahawk, 1984
Fred H Koenecke, MD, Madison, 1984

Warren H Williamson, MD, Racine, 1984
Roland E Herrington, MD, Milwaukee, 1985
Marwood E Wegner, MD, St Croix Falls, 1985
David L Nelson, MD, Stoughton, 1985

Environmental and Occupational Health

This committee may have up to 15 members and shall be concerned with the health and safety of persons in relation to their environment, including matters relating to occupational and rural health.

Melvin S Blumenthal, MD, Monroe, 1983
Robert W Page, MD, Marshfield, 1983
Steven T Rosebrock, Appleton, 1983
Wendelin W Schaefer, MD, Sheboygan, 1983
Carl Zenz, MD, West Allis, 1983
Henry A Anderson III, MD, Madison, 1984
John J Beck, MD, Sturgeon Bay, 1984
Erwin S Huston, MD, Milwaukee, 1984
Donald M Rowe, MD, Kohler, 1984
John T Schmitz, MD, Milwaukee, 1984
Vernon N Dodson, MD, Madison, 1985
Edward P Horvath Jr, MD, Marshfield, 1985
George H Handy, MD, Madison, 1985
Larry A Lindesmith, MD, La Crosse, 1985
Charles W Fishburn, MD, New Berlin, 1985
Mrs W W (Jame) Schaefer, Sheboygan, Auxiliary

Maternal and Child Health

This committee shall be concerned about all aspects of health in pregnancy, childbirth and children, with special emphasis on the reduction of maternal mortality and the prevention of disease or disability in children.

Gary R Gutcher, MD, Madison, 1983
John E Inman, MD, Monroe, 1983
Joanne Selkurt, MD, Whitehall, 1983
Gloria M Halverson, MD, Waukesha, 1984
Daniel F Johnson, MD, Eau Claire, 1984
Sharon L Maby, MD, Marshfield, 1984
Walter R Schwartz, MD, Wauwatosa, 1984
Edward J Buerger, MD, Waukesha, 1985
Michael H Mader, MD, La Crosse, 1985
Kilian H Meyer, MD, Richland Center, 1985
Curtis R Weatherhogg, MD, Madison, 1985

SUBCOMMITTEE

Study Committee on Maternal Mortality Survey

Harold Borkowf, MD, Milwaukee
Richard C Brown, MD, Eau Claire
Gloria M Halverson, MD, Waukesha
Perry A Henderson, MD, Madison
Frederick J Hofmeister, MD, Wauwatosa
Stanley A Korducki, MD, Milwaukee
Thomas A Leonard, MD (Emeritus), Middleton
Ronald W Olson, MD, Madison
Ben M Peckham, MD, Madison
Robert P Reik, MD, Wauwatosa
Herbert F Sandmire, MD, Green Bay
Albert H Stahmer, MD, Wausau
Everett A Beguin, MD, La Crosse
John E Inman, MD, Monroe
Dan F Johnson, MD, Eau Claire
Richard F Mattingly, MD, Milwaukee
William E Martens, MD, Wauwatosa
Bernard Poeschel, MD, Eau Claire

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Medicine and Religion

This committee shall be concerned about the medical-spiritual values of health care and the development of closer relationships between physicians and clergy to permit discussion of common problems in the total treatment and care of patients.

John W Faber, MD, Neenah, 1983
E Basil Jackson, MD, Milwaukee, 1983
G Daniel Miller, MD, Oconomowoc, 1983
John K Scott, MD, Madison, 1983
Maxwell H S Weingarten, MD, Milwaukee, 1983
Frank J Cerny, MD, Fond du Lac, 1984
Dennis G Greer, MD, Wautoma, 1984
William O Myers, MD, Marshfield, 1984
Richard W Shropshire, MD, Madison, 1984
Donald A Wollheim, MD, Wauwatosa, 1984
Glenn H Franke, MD, Milwaukee, 1985
John P Mullooly, MD, Milwaukee, 1985
James V Seegers, MD, Elkhorn, 1985
John O Simenstad, MD, Osceola, 1985
John B Weeth, MD, La Crosse, 1985

Mental Health

This committee shall be concerned with all aspects of mental health as an equal part of the patient's total well-being.

Edward D Meyer, MD, Oshkosh, 1983
Theodore J Nereim, MD, Mount Horeb, 1983
Robert F Goerke, MD, Milwaukee, 1984
Charles W Landis, MD, Milwaukee, 1984
Clarence E Moore, MD, Fond du Lac, 1984
David P Donarski, MD, Green Bay, 1985
William W Garitano, MD, Marshfield, 1985
Pauline M Jackson, MD, LaCrosse, 1985
Warren A Olson, MD, Madison, 1985

Safe Transportation

This committee shall be concerned about the health and safety of all who may be affected by the use of vehicles of transportation on land, water, or in the air.

James M Huffer, MD, Madison, 1983
Elmer E Johnson, MD, Madison, 1983
Clarence E Moore, MD, Fond du Lac, 1983
Frederick Bunkfeldt Jr, MD, Milwaukee, 1984
Glenn C Hillery, MD, Lancaster, 1984
Kathryn P Nichol, MD, Madison, 1984
James L Weygandt, MD, Sheboygan Falls, 1984
David K Dunn, MD, Milwaukee, 1985
Eugene E Eckstam, MD, Monroe, 1985
Ralph F Hudson, MD, Eau Claire, 1985
Walter F Smejkal, MD, Manitowoc, 1985

School Health

This committee shall be concerned about protecting and improving the health of those attending the public or private schools of this state, including matters related to athletics.

William T Brodhead, MD, Madison, 1983
Lawrence K Siegel, MD, Waukesha, 1983
George H Handy, MD, Madison, 1984
Rolf L Simonson, MD, Sheboygan, 1984
Horace K Tenney III, MD, Madison, 1984
Conrad L Andringa, MD, Madison, 1985
Parnell Donahue, MD, Hartford, 1985
James C H Russell, MD, Ft Atkinson, 1985
Mrs Kenneth (Mary) Smigielski, Milwaukee, Auxiliary

Women Physicians

This committee shall serve as liaison and women's advocate with other commissions and committees of the State Medical Society. It shall encourage state, county, and specialty societies to make special efforts to recruit women physicians to membership in organized medicine, subsequently to consider them for leadership positions based on their professional capabilities rather than as women physicians. It shall promote medical education that is sensitive and responsive to women's healthcare needs and enhance educational opportunities for women. It also shall serve as a resource to the State Medical Society, other groups, and individuals on women's health issues. It shall consist of nine members appointed by the Board of Directors.

Carl S Eisenberg, MD, Milwaukee, 1983
Pauline M Jackson, MD, La Crosse, 1983
Janet C Lindemann, MD, Waukesha, 1983 (resident)
Sandra L Osborn, MD, Madison, 1983
Kathryn C Bemmann, MD, Waukesha, 1984
Lucille B Glicklich, MD, Milwaukee, 1984
Hansi R Patience, MD, Sturgeon Bay, 1984
Mrs Donald A (Audrey) Peterson, Madison, Auxiliary, 1985
Patricia J Stuff, MD, Bonduel, 1985
Carol Young, MD, Milwaukee, 1985
Chesley P Erwin, MD, Milwaukee, President-elect (ex officio)■

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DISTRICT 1
Lois Riley
(414/271-4328)
Susan McHugh
(414/355-5262)

County medical societies

Milwaukee
Ozaukee
Washington
Waukesha
Walworth
Racine
Kenosha

DISTRICT 2
Lanny Hardy
(608/831-8014)

County medical societies

Columbia-Marquette-Adams
Green Lake-Waushara
Rock
Green
Lafayette
Iowa
Richland
Grant
Vernon
Sauk
Juneau
Dodge
Jefferson
Dane

DISTRICT 3
Kris Bjurstrom
(414/921-4407)

County medical societies

Marientte-Florence
Oconto
Shawano
Door-Kewaunee
Brown
Outagamie
Waupaca
Manitowoc
Winnebago
Calumet
Fond du Lac
Sheboygan

DISTRICT 4
Paul Jacobson
(715/835-1753)
(715/874-6125)

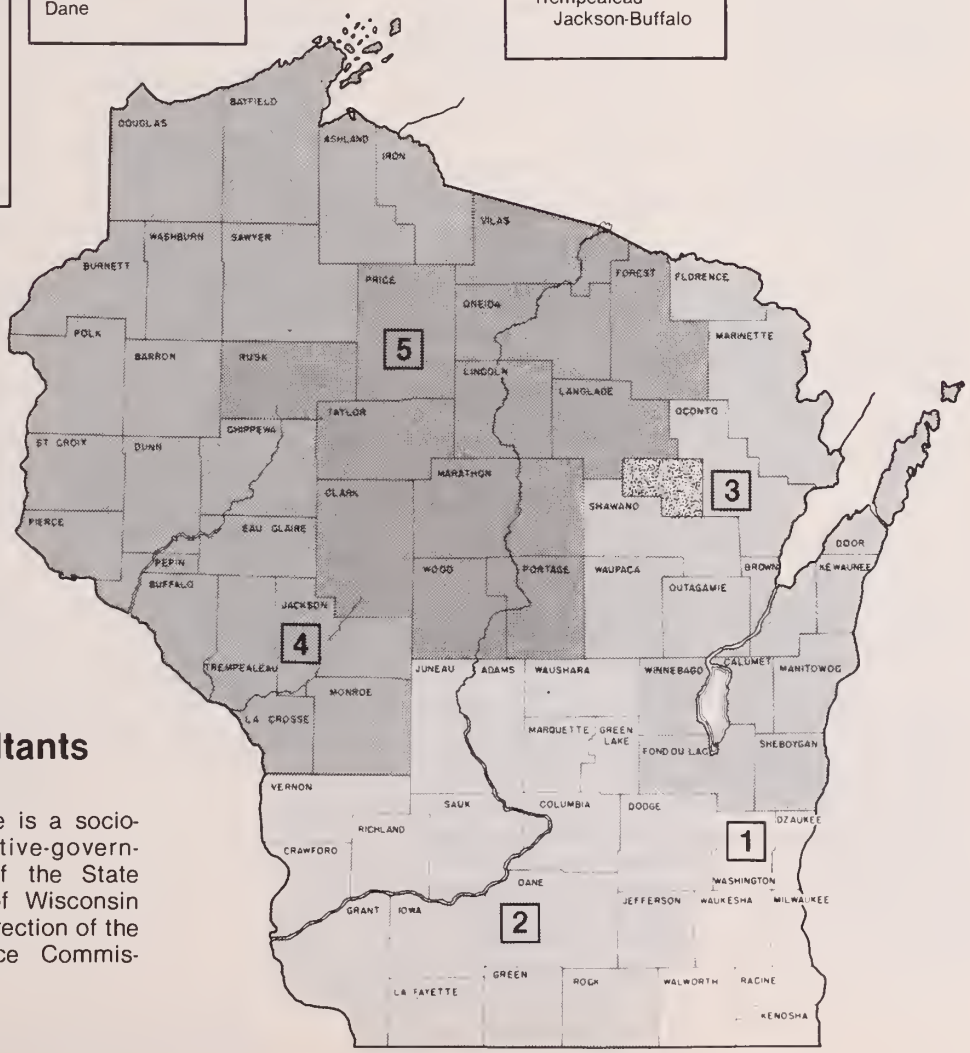
County medical societies

Ashland-Bayfield-Iron
Douglas
Barron-Washburn-Burnett
Sawyer
Polk
Pierce-St Croix
Chippewa
La Crosse
Monroe
Eau Claire-Dunn-Pepin
Trempealeau-Jackson-Buffalo

DISTRICT 5
Ron Henrichs
(715/536-7070)

County medical societies

Oneida-Vilas
Price
Rusk
Taylor
Lincoln
Langlade
Marathon
Clark
Wood
Portage



1982 Physicians Alliance Districts and Field Consultants

Physicians Alliance is a socio-economic-legislative-governmental division of the State Medical Society of Wisconsin and is under the direction of the Physicians Alliance Commission.

COUNTY MEDICAL SOCIETIES

Presidents (P) and Secretaries (S); Executive Secretaries (ES), Treasurers (T), and Executive Vice Presidents (EVP)

ASHLAND-BAYFIELD-IRON
P—Edward M Vernier, MD
2101 Beaser Ave, #9
Ashland, WI 54806
S—Ivan Teoh, MD
2101 Beaser Ave
Ashland, WI 54806

BARRON-WASHBURN-BURNETT
P—Donald E Riemer, MD
PO Box 127
Cumberland, WI 54829
S—Mark T Nymo, MD
1020 Lake St
Rice Lake, WI 54868

BROWN
P—Donald R Sipes, MD
1061 West Mason St
Green Bay, WI 54303
S—James R Mattson, MD
501 S Military Ave
Green Bay, WI 54301
T—Roger C Wargin, MD
PO Box 3875
Green Bay, WI 54303
ES—Ms Bernice Mangless
501 S Military Ave
Green Bay, WI 54301

CALUMET
P—Badri N Ganju, MD
451 East Brooklyn
Chilton, WI 53014
S—James C Pinney, MD
507-C West Main St
Hilbert, WI 54129

CHIPPEWA
P—Richard D Kennedy, MD
2507 County Trk I
Chippewa Falls, WI 54729
S—Steven D Cook, MD
2501 County Trk I
Chippewa Falls, WI 54729

CLARK
P—Narasimhulu Neelagaru, MD
110 Park St
Neillsville, WI 54456
S—Federico P Gregorio, MD
216 Sunset Pl
Neillsville, WI 54456

COLUMBIA-MARQUETTE-ADAMS
P—Ramakrishnan Sankaran, MD
PO Box 10
Friendship, WI 53934
S—Richard E Christianson, MD
916 Silver Lake Dr
Portage, WI 53901
ES—Mrs Elayne Hanson
PO Box 352
Portage, WI 53901

CRAWFORD
P—Thomas F Farrell, MD
323 South Beaumont Rd
Prairie du Chien, WI 53821
S—Michael S Garrity, MD
610 E Taylor St
Prairie du Chien, WI 53821

DANE
P—Alwin E Schultz, MD
222 N Midvale Blvd
Madison, WI 53705
S—Richard D Lindgren, MD
6003 Green Tree Rd
Madison, WI 53711

DODGE
P—Vicki R Prell, MD
130 Warren St
Beaver Dam, WI 53916
S—George E Davis, MD
130 Warren St
Beaver Dam, WI 53916

DOOR-KEWAUNEE
P—Ferrin C Holmes, MD
PO Box 447
Sturgeon Bay, WI 54235
S—Michael R McFadden, MD
PO Box 447
Sturgeon Bay, WI 54235

DOUGLAS
P—Thomas J Doyle, MD
1507 Tower Ave
Superior, WI 54880
S—Paul S Muenzer, MD
3500 Tower Ave
Superior, WI 54880

EAU CLAIRE-DUNN-PEPIN
P—Philip J Happe, MD
733 W Clairemont Ave
Eau Claire, WI 54701
S—Daniel F Johnson, MD
733 W Clairemont Ave
Eau Claire, WI 54701

FOND DU LAC
P—Douglas R Fownes, MD
505 E Division St
Fond du Lac, WI 54935
S—Gay D Trepanier, MD
481 E Division St
Fond du Lac, WI 54935
T—John C Swan, MD
Mount Calvary, WI 53057

FOREST
P—Enzo F Castaldo, MD
Laona, WI 54541
S—Burton S Rathert, MD
101 W Washington
Crandon, WI 54520

GRANT
P—John M McKichan, MD
1370 N Water St
Platteville, WI 53818
S—Robert E Stader, MD
235 N Madison St
Lancaster, WI 53813

GREEN
P—Geoffrey L Tullett, MD
1515 Tenth St
Monroe, WI 53566
S—Jacob George, MD
1515 Tenth St
Monroe, WI 53566

GREEN LAKE-WAUSHARA
P—Alonzo R Giminez, MD
PO Box 350
Berlin, WI 54923
S—Michael E Tieman, MD
Route 2
Berlin, WI 54923

IOWA
P—Timothy A Correll, MD
109 W Fountain St
Dodgeville, WI 53533
S—Harald P L Breier, MD
PO Box 185
Montfort, WI 53569

JEFFERSON
P—Frederick C Gemmels, DO
127 Hospital Dr
PO Box 49
Watertown, WI 53094
S—Bruce J Cochrane, MD
127 Hospital Dr
PO Box 49
Watertown, WI 53094

JUNEAU
S—Jack Strong, MD
1040 Division St
Mauston, WI 53948

KENOSHA
P—Lee H Huberty, MD
8747 First Ave
Kenosha, WI 53140
S—Anoo P Patel, MD
5942 Sixth Ave
Kenosha, WI 53140
ES—Mr James Splitek
4109 - 67th St
Kenosha, WI 53142

LA CROSSE
P—Stephen B Webster, MD
1836 South Ave
La Crosse, WI 54601
S—Thomas P Lathrop, MD
1836 South Ave
La Crosse, WI 54601

LAFAYETTE

LANGLADE
P—John E McKenna, MD
PO Box 400
Antigo, WI 54409
S—Theodore C Fox, MD
213 Fifth Ave
Antigo, WI 54409

LINCOLN
P—Geoffrey C Kloster, MD
1205 O'Day St
Merrill, WI 54452
S—Donald L Evans, MD
1205 O'Day St
Merrill, WI 54452

MANITOWOC
P—Thomas A Keller, MD
21st & Western Ave
Manitowoc, WI 54220
S—Steven D Driggers, MD
600 York St
Manitowoc, WI 54220

MARATHON
P—Teofilo O Odulio, MD
425 Pine Ridge Blvd, #301
Wausau, WI 54401
S—Gerald W Grim, MD
2727 Plaza Dr
Wausau, WI 54401

MARINETTE-FLORENCE
P—Clark H Boren, MD
1510 Main St
Marinette, WI 54143
S—Steven H Hoyme, MD
801 Wells St
Marinette, WI 54143

MILWAUKEE
P—Glenn H Franke, MD
324 E Wisconsin Ave, #1330
Milwaukee, WI 53202
S—Robert J Flemma, MD
9800 W Bluemound Rd
Milwaukee, WI 53226
EVP—Mr Michael McManus
411 E Mason St
Milwaukee, WI 53202

MONROE
P—Gustave A Landmann, MD
PO Box 729
Tomah, WI 54660
S—Jack D Brown, MD
PO Box 250
Sparta, WI 54656

OCONTO
P—Kenneth L Strebe, MD
103 John St
Oconto Falls, WI 54154
S—Clyde E Siefert, MD
164 N Main St
Oconto Falls, WI 54154

ONEIDA-VILAS
P—Benn A Haynes, MD
830 Messer St
Rhinelander, WI 54501
S—Daniel L Johnson, MD
Rte 1, Box 705
Rhinelander, WI 54501

OUTAGAMIE
P—C William Freeby, MD
229 S Morrison St
Appleton, WI 54911
S—Henry Chessing, MD
424 E Wisconsin Ave
Appleton, WI 54911

OZAUKEE
P—M Thomas Chemotti, MD
N94 W6539 Fieldcrest
Cedarburg, WI 53012
S—Thomas J Shewczyk, MD
W62 N563 Washington Ave
Cedarburg, WI 53012

PIERCE-ST CROIX
P—Colin J Drury, MD
PO Box 68
New Richmond, WI 54017
S—David M Woeste, MD
409 Spruce St
River Falls, WI 54022

POLK
P—William R Byrne, MD
127 Keller Ave N
Amery, WI 54001
S—William W Young, MD
104 Adams St S
St Croix Falls, WI 54024

PORTAGE
P—David E Enerson, MD
1201 Soo Marie Ave
Stevens Point, WI 54481
S—Joseph F Jarabek, MD
2501 Main St
Stevens Point, WI 54481

PRICE-TAYLOR
S—Walther W Meyer, MD
101 N Gibson Ave
Medford, WI 54451

RACINE
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3801 Spring St
Racine, WI 53405
S—Indur B Wadhwani, MD
3803 Spring St, #204
Racine, WI 53405
T—Carroll M Martin, MD
407 13th St
Racine, WI 53403
ES—Mr John M Bjelajac
PO Box 592
Racine, WI 53401

RICHLAND
P—Dale F Sinnett, MD
Rte #4
Richland Center, WI 53581
S—L Maramon Pippin, MD
1313 West Seminary St
Richland Center, WI 53581

ROCK
P—William N Brandt, MD
PO Box 551
Janesville, WI 53545
S—Arthur C Plautz Jr, MD
580 N Washington St
Janesville, WI 53545

RUSK
P—Howard T Chatterton, MD
906 College Ave W
Ladysmith, WI 54848
S—Norman A Desbiens, MD
906 College Ave W
Ladysmith, WI 54848

SAUK
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1900 N Dewey Ave
Reedsburg, WI 53959
S—John R Van Tuyl, MD
1225 Pineview Dr
Reedsburg, WI 53959

SAWYER
P—Lloyd M Baertsch, MD
Rte 6, Box 700
Hayward, WI 54843
S—Paul Strapon III, MD
Rte 6, Box 700
Hayward, WI 54843

SHAWANO
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117 E Green Bay St
Shawano, WI 54166
S—Alois J Sebesta, MD
126½ South Main St
PO Box 360
Shawano, WI 54166

SHEBOYGAN
P—James B Kuplic, MD
1226 North 8th St
Sheboygan, WI 53081
S—James L Weygandt, MD
Kohler Company
Kohler, WI 53044

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Rte 2
Galesville, WI 54630
S—James J Dickmann II, MD
610 West Adams St
Black River Falls, WI 54615

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P—Phillips T Bland, MD
100 Melby St
Westby, WI 54667
S—DeVerne W Vig, MD
PO Box 72
Viroqua, WI 54665

WALWORTH
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Rte 4, Box 246
Lake Geneva, WI 54147
S—James V Seegers, MD
104 S Wisconsin St
Elkhorn, WI 53121

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1201 Oak St
West Bend, WI 53095
S—Uday V Gupte, MD
1113 East Sumner St
Hartford, WI 53027

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Pewaukee, WI 53072
S—Thomas J Dougherty, MD
1111 Delafield St
Waukesha, WI 53186
T—James E Dall, MD
1111 Delafield St
Waukesha, WI 53186
ES—Mr Robert Herzog
850 Elm Grove Rd
Elm Grove, WI 53122

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P—D Mark Lochner, MD
PO Box 387
Waupaca, WI 54981
S—Donn D Fuhrmann, MD
1420 Algoma St
New London, WI 54961

WINNEBAGO
P—Roy E Buck, MD
111 E North Water St
Neenah, WI 54956
S—Edwin L Downing, MD
719 Doctors Ct
Oshkosh, WI 54901

WOOD
P—John W McDonough, DO
4540 Church Ave
Wisconsin Rapids, WI 54494
S—William J Maurer, MD
1000 North Oak Ave
Marshfield, WI 54449■

WHETHER TO INCORPORATE

COUNTY AND SPECIALTY societies who have questions regarding incorporation, in what category they should seek tax exemption, and the mechanics of doing either or both of these are encouraged to consult H B Maroney, State Medical Society assistant secretary and corporate legal counsel, at SMS headquarters in Madison.

OFFICERS OF SPECIALTY SECTIONS* OF THE STATE MEDICAL SOCIETY as of record July 1, 1982

Section on:

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Chairman .....

Secretary-treasurer .....

Delegate ..... Martin Z Fruchtman, MD
217 Wisconsin Ave, Waukesha 53186

Alternate Delegate ..... John J Ouellette, MD
1 S Park St, Madison 53715

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1421-14th Ave, Monroe 53566

Secretary-treasurer ..... W Stuart Sykes, BM
1005 Columbia Rd, Madison 53705

Delegate ..... Warren J Holtey, MD
1000 N Oak, Marshfield 54449

Alternate Delegate ..... James J Brill, MD
20 S Park St, Madison 53715

DERMATOLOGY

Chairman ..... Eugene W Monroe, MD
3003 W Good Hope Rd, Milwaukee 53209

Secretary-treasurer ..... Robert A McDonald, MD
1313 Fish Hatchery Rd, Madison 53715

Delegate ..... Joel E Taxman, MD
1622 W Wisconsin Ave, Milwaukee 53233

Alternate Delegate ..... Nyles Eskritt, MD
3508 E Maria Dr, Stevens Point 54481

EMERGENCY MEDICINE

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2404 Hawthorne Lane, Wausau 54401

Secretary-treasurer ..... Joan M Gennrich, MD
1961 North Summit, Milwaukee 53202

Delegate .....

Alternate Delegate .....

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815 S 10th St, La Crosse 54601

Delegate ..... Robert F Purtell Jr, MD
3316 West Wisconsin Ave, Milwaukee 53208

Alternate Delegate ..... Stuart L Goldman, MD
610 North 19th St, Milwaukee 53233

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Delegate ..... Anthony P Ziebert, MD
2400 South 90th St, #306, Milwaukee 53227

Alternate Delegate .....

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Secretary-treasurer .....

Delegate ..... Mark J Ciccantelli, MD
610 N 19th St, Milwaukee 53233

Alternate Delegate ..... Manucher J Javid, MD
600 Highland Ave, Madison 53792

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704 S Webster St, Green Bay 54301

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2500 Overlook Terr, Madison 53706

Delegate ..... Michael P McQuillen, MD
8700 W Wisconsin Ave, Milwaukee 53226

Alternate Delegate .....

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Delegate ..... Werner E Langheim, MD
20 South Park St, Madison 53715

Alternate Delegate ..... Allan B Levin, MD
600 Highland Ave, Madison 53792

OBSTETRICS-GYNECOLOGY

Chairman ..... William J Madden, MD
2405 Northwestern Ave, Racine 53404

Secretary-treasurer ..... Walter R Schwartz, MD
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Delegate ..... William E Martens, MD
10425 W North Ave, Wauwatosa 53226

Alternate Delgate .....

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6114 W Capitol Dr, Milwaukee 53216

Secretary-treasurer ..... Reed C Andrew, MD
417 S Monroe Ave, Green Bay 54301

Delegate ..... Robert D Sullivan, MD
612 E Longview, Appleton 54911

Alternate Delegate ..... None

*Appointments to these Sections are generally made by the Specialty Societies. In some instances the appointees are not members of the State Medical Society and thus cannot serve in an official capacity; these names have been omitted.

ORTHOPAEDICS

Chairman ..... Donald R Gore, MD
1226 North 8th St, Sheboygan 53081
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1226 North 8th St, Sheboygan 53081
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1218 W Kilbourn Ave, Milwaukee 53233
Alternate Delegate ..... David D Mellencamp, MD
3970 N Oakland Ave, #501, Milwaukee 53211

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1836 South Ave, LaCrosse 54601
Delegate ..... Glenn M Seager, MD
1836 South Ave, LaCrosse 54601
Alternate Delegate ..... David M Wineinger, MD
923 Eliza St, Green Bay 54301

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Delegate ..... Edward A Burg, MD
2025 E Newport Ave, Milwaukee 53211
Alternate Delegate ..... Robert E Carlovsky, MD
430 E Division St, Fond du Lac 54935

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Secretary-treasurer .....

Delegate ..... Curtis R Weatherhogg, MD
20 South Park St, Madison 53715
Alternate Delegate ..... Carl S L Eisenberg, MD
3003 W Good Hope Rd, Milwaukee 53209

PHYSICAL MEDICINE AND REHABILITATION

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12535 Stephen Pl, Elm Grove 53122
Secretary-treasurer ..... Neal Taylor, MD
1836 South Ave, LaCrosse 54601
Delegate ..... William J LaJoie, MD
1545 South Layton Blvd, Milwaukee 53215
Alternate Delegate ..... Basilio F Lopez, MD
2015 E Newport Ave, Milwaukee 53211

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Delegate ..... Vaughn Demergian, MD
345 W Washington Ave, Madison 53703
Alternate Delegate .....

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Box 224, Eau Claire 54701
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Delegate ..... Fred H Koencke Jr, MD
2727 Marshall Court, Madison 53705
Alternate Delegate ..... Paul S Johnson, MD
211-9th, Racine 53403

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Chairman ..... Richard W Biek, MD
1610 E Newport Ave, Milwaukee 53211
Secretary-treasurer ..... Constantine Panagis, MD
9609 W Hadley, Milwaukee 53222
Delegate ..... Richard W Biek, MD
1610 E Newport Ave, Milwaukee 53211
Alternate Delegate ..... Paul R Ebling, MD
2500 Overlook Terr, Madison 53705

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Box 3006, Green Bay 54303
Alternate Delegate ..... Bruce C Kirkham, MD
3737 Claymore Lane, Eau Claire 54701

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Secretary-treasurer .....

Delegate ..... Kay E Jewell, MD
215 Keleen Dr, Waupaca 54981
Alternate Delegate ..... Mark F Liebow, MD
1431 Morrison St, Madison 53703

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PO Box 551, Janesville 53545
Alternate Delegate ..... Louis C Bernhardt, MD
501 Shearwater Rd, Madison 53714

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Alternate Delegate ..... Clyde Lawnicki, MD
1836 South Ave, LaCrosse 54601 ■

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President ..... William W Busse, MD (Oct 1982)
H6/360 UW Center for Health Sciences
600 Highland Ave, Madison 53792
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9505 N Pheasant Lane, River Hills 53217

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1421-14th Ave, Monroe 53566
Secretary ..... W Stuart Sykes, BM (Sept 1982)
1005 Columbia Rd, Madison 53705

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3003 W Good Hope Rd, Milwaukee 53209
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143 Division St, Mauston 53948
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850 Elm Grove Rd, Elm Grove 53122

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Secretary ..... D Scott Sellinger, MD (Nov 1982)
1226 North 8th St, Sheboygan 53081

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Secretary ..... Ordean L Torstensen, MD (Oct 1982)
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Secretary ..... William J LaJoie, MD (Apr 1983)
S32 W27641 Daleview Dr, Waukesha 53186

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345 W Washington Ave, Madison 53703
Secretary ..... Alan L Pohl, MD (May 1983)
10425 W North Ave, Wauwatosa 53226

continued next page

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President ..... Jack D Edson, MD (Jan 1983)
Box 224, Eau Claire 54701
Secretary ..... James A Alston, MD (Jan 1983)
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Executive Secretary ..... Mr Howard Brower
PO Box 1109, Madison 53701

WISCONSIN SOCIETY FOR PREVENTIVE MEDICINE

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1610 E Newport Ave, Milwaukee 53211
Secretary ..... Constantine Panagis, MD (May 1983)
9609 W Hadley, Milwaukee 53222

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2320 N Lake Dr, Milwaukee 53217
Secretary ..... Stanton A Marks, MD (May 1983)
5000 West Chambers Ave, Milwaukee 53210

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Secretary ..... Mary Ellen Peters, MD (Oct 1982)
600 Highland Ave, Madison 53792

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1751 Deckner, Green Bay 54302
Secretary ..... Gale L Mendeloff, MD (May 1983)
2015 E Newport, Milwaukee 53211

WISCONSIN CHAPTER, AMERICAN COLLEGE OF SURGEONS

President ..... J David Lewis, MD (Sept 1982)
279 S 17th Ave, Box 178, West Bend 53095

SPECIALTY CERTIFICATION

WISCONSIN PHYSICIANS are reminded that it is their responsibility, as well as to their advantage, to keep WPS-Medicare informed of any change in their specialty or certification status. To alleviate any confusion, each physician should be sure that the same specialty is shown with the various societies; *eg,* AMA, State Medical Examining Board and the State Medical Society. There have been some instances where a different specialty was shown with each organization. Written documentation of such changes should be directed to the WPS-Medicare insurance company office, ATTENTION-CPCU (Central Provider Control Unit). If you have any questions concerning the specialty WPS-Medicare currently has on file for you, contact Mrs Johnson, CPCU, (608) 221-4711, ext 420.

Physicians also are urged to provide the same information to the Medicaid administrator: EDS-Federal, Attention Provider Maintenance. The contact person is Gary Holtzman (phone: 608/221-4746).

Secretary ..... Paul S Fox, MD (Sept 1982)
1111 Delafield, Waukesha 53186

WISCONSIN UROLOGICAL SOCIETY

President ..... Charles W Troup, MD (May 1983)
2021 S Webster Ave, Green Bay 54301
Secretary ..... Richard W Roberts, MD (May 1983)
400 Ceape Ave, Oshkosh 54901 ■

WISCONSIN SPECIALTY SOCIETY MEETINGS: 1982-1983

Wisconsin Society of Obstetrics & Gynecology, July 23-24, 1982, Leathem Smith Lodge, Sturgeon Bay

Wisconsin Dermatological Society, Aug 6-8, 1982, The Abbey, Lake Geneva

Wisconsin Otolaryngological Society, Aug 28-29, 1982, The Abbey, Lake Geneva

Wisconsin Neurological Society, Fall Meeting, Sept 17-19, American Club, Kohler

Wisconsin Surgical Society, Sept 9-10, 1982, Holiday Inn and/or Radisson Hotel, La Crosse

Wisconsin Society of Internal Medicine, Sept 9-11, 1982, Holiday Inn (Downtown), Green Bay

Wisconsin Society of Anesthesiologists, Sept 9-12, 1982, Concourse Hotel, Madison

Wisconsin-Upper Michigan Society of Ophthalmology Annual Meeting, Sept 18, 1982, Marshfield

Wisconsin Radiological Society, Oct 16, 1982 Concourse Hotel, Madison

Wisconsin Allergy Society, Nov 6-7, 1982, Pioneer Inn, Oshkosh

Wisconsin Chapter: American College of Emergency Medicine, October 1982, The Pfister Hotel & Tower, Milwaukee

Wisconsin Orthopaedic Society, Nov 5, 1982 Olympia Resort, Oconomowoc

* * *

SPECIALTY SOCIETY MEETINGS TO BE HELD IN CONJUNCTION WITH SMS ANNUAL MEETING, March 24-26, 1983, Milwaukee

Wisconsin Allergy Society
Wisconsin Orthopaedic Society
Wisconsin Society of Internal Medicine
Wisconsin Society of Pathologists
Wisconsin Society of Physical Medicine and Rehabilitation
Wisconsin Society of Plastic Surgeons
Wisconsin Society for Preventive Medicine
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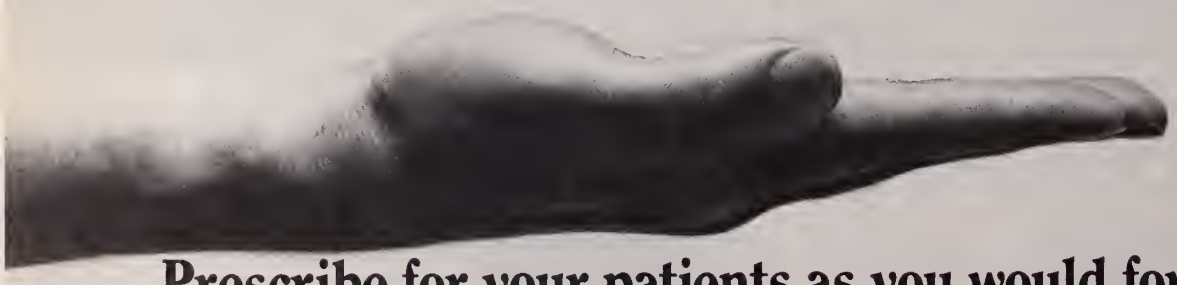

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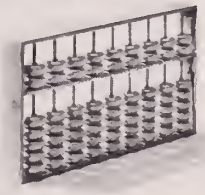

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STATE GOVERNMENT AGENCIES

A VALUABLE REFERENCE FOR PRACTICING PHYSICIANS AND ALLIED HEALTH PERSONNEL

AS OF JUNE 15, 1982

Department of Health and Social Services

1 W Wilson St, Madison, Wis 53702 • Tel 608/266-3681

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DEPUTY SECRETARY
Helene Nelson 266-3681

DIVISION ADMINISTRATORS
Peter Tropman 266-8402
Policy and Budget

Nate Harris 266-3173
Management Services

Elmer Cady 266-2471
Corrections

Bernard Stumbras 266-3416
Economic Assistance

Kenneth Rentmeester 266-1511
Health

Burton Wagner 266-2701
Community Services

Patricia Kallsen 266-1281
Vocational Rehabilitation

DIVISION OF HEALTH

1 W Wilson St; Room 280
PO Box 309
Madison, Wis 53701
Tel 608/266-1511
Note: Use box number on First Class Mail for all bureaus.

ADMINISTRATOR
Kenneth Rentmeester

ASSISTANT ADMINISTRATOR for Public Health Services
Vacancy

ASSISTANT ADMINISTRATOR for Health Administration
Dan Jehl

OFFICE OF OPERATIONS AND MANAGEMENT
Tom Johnson

BUREAUS

Planning & Development ... 266-2020
- Staffing of Health Policy Council and its committees
- Development of State Health Plan
- Liaison with Health Systems Agencies and review of their plans and budgets
- Coordination of categorical health planning process
- Review of categorical health plans
- Liaison with agencies (public and private) that implement the State Health Plan
- Service licensure
- Development of health facilities plan
- Review of categorical grants appeal

Health Care Financing 266-2522
- Administration of the Medical Assistance Program
- EPSDT—Early and periodic screening, diagnosis and treatment for children and other screening activities
- Hospital rate review

Quality Compliance 266-8847
- Title 18 and Title 19 certification
- Hospital and nursing home standard setting and enforcement
- Patient care evaluation
- Construction and plan review
- Development of facilities standards

Community Health & Prevention 266-1251
- Development and promotion of prevention programs
- Standard epidemiology
- Environmental epidemiology
- Immunization activities
- Communicable diseases
- Chronic diseases
- Participation in preventive efforts within and outside the Department of Health and Social Services
- Promotion of research into major causes of illness and death and sponsorship of demonstration projects designed to reduce and eliminate root causes
- Laboratory certification
- Public health nursing
- Public health nutrition
- Dental health
- Maternal and child health
- Family planning

Correctional Health Services 266-5718
- Assurance of sufficient levels of physical health care for all inmates in correctional institutions and at Central State Hospital
- Management of the provision of such services to insure effectiveness and efficiency
- Recruitment and staffing of health care positions in the correctional institutions

Environmental Health 266-1704
(1400 E Washington Ave, Madison 53702)
- Certification of Grade A milk
- Inspection of hotels, restaurants and food vending services where not performed by local public health agencies
- General environmental sanitation
- Recreational inspection
- Radiation protection
- Occupational health services
- Development of emergency medical services systems

Health Statistics 266-1939
- Vital Statistics
- Resource data
- Demographic and special analysis
- Services data

REGIONAL OFFICES

1—MADISON 53701
1 W Wilson, PO Box 309
Tel 608/266-2245

2—MILWAUKEE 53216
6815 W Capitol Dr
Tel 414/257-4891

3—FOND DU LAC 54935
485 S Military Rd; PO Box 269
Tel 414/922-1290

4—GREEN BAY 54304
1298 Lombardi Ave
Tel 414/497-3219

5—LACROSSE 54601
District State Office Building, 104
3550 Mormon Coulee Rd
Tel 608/785-9431

6—EAU CLAIRE 54701
Eau Claire State Office Building, 136
718 W Clairemont Ave
Tel 715/836-5362

7—WISCONSIN RAPIDS 54494
District State Office Building
1681 Second Ave S; PO Box 277
Tel 715/423-4730

continued next page

DIVISION OF HEALTH *continued*

7—RHINELANDER 54501
1831 N Stevens St; PO Box 1165
Tel 715/369-2840

8—Information should be obtained from Eau Claire District

Note: Use box numbers on First Class Mail

* * *

DIVISION OF ECONOMIC ASSISTANCE

State Office: 18 S Thornton Ave
Box 8913, Madison, Wis 53708
Tel: 608/266-3416

Administrator 266-3035
Bernard Stumbras

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Program Compliance 266-1080
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Duane Campbell, Director

Social Security Disability Insurance 266-1981
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DIVISION OF COMMUNITY SERVICES

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Madison, Wis 53702
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Gerald Berge

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Vacancy

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Vacancy

Assistant Administrator for Program 266-2701
Douglas Nelson

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Hearing Impaired 266-8081
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Office of Regulation and Licensing 266-0468
Barbara Voltz, Director

continued next page

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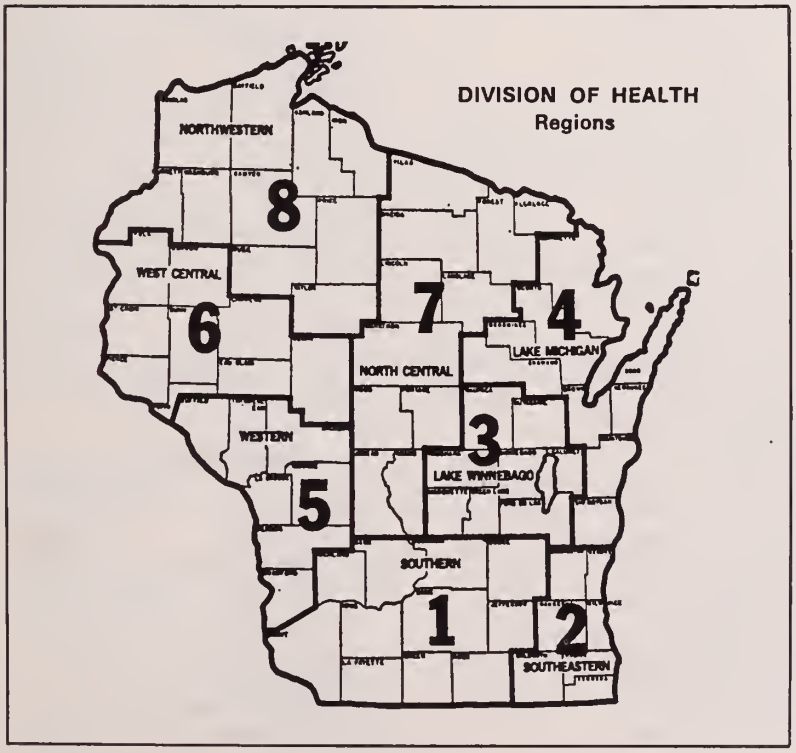
John W Calhoun, Asst Attorney General, State of Wisconsin, Madison

* * *

STAFF: Division of Community Services, Bureau of Alcohol and Other Drug Abuse, Room 434, One West Wilson St, Madison, Wis 53702 (phone 608/266-7586)



Bureau of Health Statistics Division of Health

The Bureau is the custodian of birth, death, marriage and divorce records for the state (ss. Chapter 69). Also, the Bureau has a contract with the National Center for Health Statistics for collection of vital statistics and partial funding from the Health Care Financing Administration for the collection of data on hospital discharge, health manpower, and health facilities. Several other projects are being carried out in areas such as cancer reporting, blood alcohol reporting, and emergency medical care. Another of the Bureau's activities is the production of annual population estimates for Wisconsin counties . . . a part of the Federal-State Cooperative Program of the Bureau of the Census. Inquiries may be made to: Raymond D Nashold, Director, Bureau of Health Statistics, PO Box 309, Madison, WI 53701.

DIVISON OF COMMUNITY SERVICES *continued*

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STAFF: Division of Health, Bureau of Planning, Room 280, One West Wilson St, Madison, Wis 53702 (phone 608/266-6652)

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Don Rittel, Legal Counsel
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Wisconsin State Laboratory of Hygiene

Directory of Services

Available by contacting Margaret A Hutchinson, Training Program Coordinator, State Laboratory of Hygiene, 465 Henry Mall, Madison, Wisconsin 53706; phone (608) 262-9661 or 262-1293.

Health Policy Council

The Governor's Health Policy Council is the chief health policy-making body in the State and is primarily responsible for the coordination of the seven area health systems plans into what ultimately becomes the triennial State Health Plan. The Council also advises the Department of Health and Social Services staff on major health issues and periodically reviews various statewide plans for the use of Federal categorical health funds. The Council's membership is designated by Federal Law to consist of at least 50% "consumers" with up to 40% of the membership appointed by the Governor.

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Roger Baird, Menasha 54952
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Byford Baker, Milwaukee 53205
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Tel 414/231-4540

Warren Von Ehren, Madison 53719
Tel 608/274-1820

Hilary Waukau Sr, Keshena 54135
Tel 715/799-3311

A Vincent Weber, LaCrosse 54601
Tel 608/784-5927 or 785-8218

Bonnie R Weigell, Milwaukee 53217
Tel 414/351-0618

Also, four vacancies■

MEDIGAP HOTLINE: 1-800-362-3930

Designed to answer health insurance questions.

- **Health insurance and retirement**
  How will my insurance needs change when I reach 65?
  What is a Medicare Supplement policy?
  How do different policies compare in coverage? In cost?
  What policies are currently on the market?
- **Health insurance for those over 65**
  Do I have good health care coverage?
  Am I paying for too much insurance?
  Can I replace my policy with a better one?
- **Special kinds of health insurance**
  Are cancer policies worthwhile?
  How do indemnity policies work?
  Do I need a nursing home policy?
- **Medical Assistance (Medicaid, M.A., Title XVIX**
  Am I eligible for Medical Assistance?
  Do I need private insurance with M.A.?
  What does M. A. cover?
  Where do I apply?

Medigap Hotline is a project of the Center for Public Representation in Madison. It is available to Wisconsin residents over age 65 or approaching retirement. When the Hotline is not in operation, a recording will give the scheduled times for calling.

WISCONSIN HEALTH SYSTEMS AGENCIES

(listed by district and serving the counties therein)

Federally designated, the seven Wisconsin HSAs are primarily responsible for areawide and regional health planning and resource development activities in their respective health service areas. Either public or private nonprofit entities, the consumer dominated HSAs (1) formulate Health Systems Plans; (2) initially review Certificate of Need Applications for institutional health services, equipment, and construction; (3) perform the first phase of Federally required "Appropriateness Review"; and (4) serve as a screening body for the application of Federal Health Funds. Additionally, HSAs are charged with the mandate to overcome access barriers to treatment, avoid duplication of service, and generally strive towards the improved health of area residents.

District 1: **Health Planning Council, Inc (HPC),** 310 Price Place, Suite 206, Madison 53705
George H Handy, MD, President
Paul Fleer, Executive Director (Ph 608/238-2641)
Counties: Columbia, Dane, Dodge, Grant, Green, Iowa, Jefferson, LaFayette, Richland, Rock, Sauk

District 2: **Southeastern Wisconsin Health Systems Agency, Inc (SEWHSA),** 735 North 5th Street, Milwaukee, Wisconsin 53203
Donald Fundingsland, President
Russell Julian, Executive Director (Ph 414/271-9788)
Counties: Kenosha, Milwaukee, Ozaukee, Racine, Walworth, Washington, Waukesha

District 3: **Lake Winnebago Area Health Systems Agency, Inc (LWAHSA)** 424 Washington Ave, Suite 201, Oshkosh, Wisconsin 54901
Tim McEnroe, President
Mark Weisensel, Executive Director (Ph 414/231-2907)
Counties: Calumet, Fond du Lac, Green Lake, Marquette, Outagamie, Waupaca, Waushara, Winnebago (Closed as of July 1982)

District 4: **Northeastern Wisconsin Health Systems Agency, Inc (NEWHSA)** Oak Grove Prof Bldg, 1640 Main St, Green Bay, Wisconsin 54302
Orlin Herrild, President
Dennis Riker, Executive Director (Ph 414/468-1886)
Counties: Brown, Door, Kewaunee, Manitowoc, Marienette, Menominee, Oconto, Shawano, Sheboygan (Closed as of July 1982)

District 5: **Western Wisconsin Health Systems Agency, Inc (WWHSA)** 1707 Main Street, La Crosse, Wisconsin 54601
Mrs Ellen Smith, President
Val Chilsen, Executive Director (Ph 608/785-9352)
Counties: Barron, Buffalo, Chippewa, Clark, Crawford, Dunn, Eau Claire, Jackson, LaCrosse, Monroe, Pepin, Pierce, Polk, Rusk, St. Croix, Trempealeau, Vernon

District 6: **North Central Area Health Planning Association, Inc (NCAHPA)** 207 North First Avenue, Wausau, Wisconsin 54401
Robert Pollock, President
George Snyder, Executive Director (Ph 715/845-3107)
Counties: Adams, Florence, Forest, Juneau, Langlade, Lincoln, Marathon, Oneida, Portage, Taylor, Vilas, Wood

District 7: **Health Systems Agency of Western Lake Superior, Inc** Ordean Building, Suite 202, 424 W Superior Street, Duluth, Minnesota 55802
Joseph Leek, MD, President
Felix Sereicikas, Executive Director (Ph 218/727-8371)
Wisconsin Counties: Ashland, Bayfield, Burnett, Douglas, Iron, Price, Sawyer, Washburn
Minnesota Counties: Aitkin, Carlton, Cook, Itasca, Koochiching, Lake, St. Louis■

PHYSICIAN MEMBERS OF WISCONSIN HEALTH SYSTEMS AGENCY BOARDS

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*Sigurd E Sivertson, MD, 610 N Walnut, Madison 53706
*George H Handy, MD, 6 Whitcomb Circle, #4, Madison 53711

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Northeastern Wisconsin Health Systems Agency, Inc
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330 East Lakeside St, Madison, Wis 53715/PO Box 1109, Madison, Wis 53701/Telephone: (608) 257-6791

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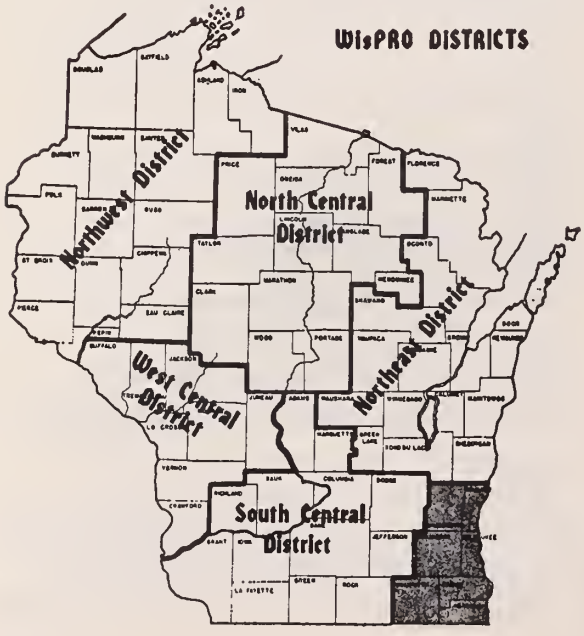

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Randall J Gall, MD, 1836 South Ave, LaCrosse 54601

continued next page

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Philip H Utz, MD, 709 South 10th St, LaCrosse 54601
Steve Laking, *District Manager,* 811 Monitor St, Suite 103, LaCrosse 54601

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LEGISLATIVE WRAP-UP . . . JUNE 1982

With the adjournment of the 1981 Session of the Wisconsin Legislature, the following wrap-up is presented to identify for you the health-related issues of interest to the Medical Society during the past two years. Of the nearly 2,000 bills introduced this session, the State Medical Society, through its Commission on Governmental Affairs and other commissions and committees, reviewed and took positions on a substantial number. Listings include the bill's primary author, a brief description of the bill, the Medical Society's position on the bill, and the bill's final status at adjournment. For further information on these issues, contact Don Lord of the Physicians Alliance Division, State Medical Society of Wisconsin (608/257-6781 or 1-800/362-9080).

MEDICAL AND PUBLIC HEALTH ISSUES

Bill/Author	Synopsis	SMS Position	Final Status
Crime Injury Reporting SB179/Sen. Cullen (D-Janesville)	Requires health care providers to report to law enforcement officials within 24 hours if the provider treats a patient with a gunshot wound, or any injury sustained in the commission of a crime or as a victim of a crime. Waives the physician/patient privilege for such reporting.	*Support in part	Died in Human Services Committee.
SB216/Sen. Frank (D-Milwaukee)	Generally the same as SB 179. *SMS supported reporting gunshot wounds only.	*Support in part	Passed Senate. Died in Assembly Judiciary Committee.
VD Treatment Advertising SB206/Human Services Committee	Repeals a 1906 law which prohibits persons from publishing advertisements on the availability of treatment for veneral disease and for certain outdated sexual conditions.	Support	Indefinitely postponed in Senate.
AB711/Health & Human Services Committee	**Contains same provision as SB 206.**	**Support**	**Law. (Chapter 291, Laws of 1981.)**
SB494/Sen. Braun (D-Milwaukee)	Same as SB 206, except it repeals the prohibition from publishing advertisements on VD treatment availability only.	Support	Died in Human Services Committee.
Determination of Death SB327/Sen. Risser (D-Madison)	**Establishes two standards for determining death. One is based on irreversible cessation of cardio-respiratory function, and the other is based on irreversible cessation of all function of the entire brain, including the brain stem. Determination of death must be made in accordance with accepted medical standards.**	**Support**	**Law. (Chapter 134, Laws of 1981.)**
Pharmacy Laws SB437/Sen. Goyke (D-Oshkosh)	Repeals and recreates the laws affecting the practice of pharmacy. Requires physicians who dispense to be so licensed by the Pharmacy Examining Board (oppose). Eliminates a physician's authority to prepare and compound prescription drugs for dispensing (oppose). Requires physicians who dispense to maintain a medication profile record system for drugs dispensed to a particular patient (oppose). Allows pharmacists to independently administer prescription drugs (opposed). Requires physicians to properly label and maintain proper records of drugs dispensed (support). Allows nurses to prescribe drugs pursuant to written protocols established and approved by a physician (oppose).	Oppose*	Passed Senate. Died in Joint Finance Committee.

MEDICAL AND PUBLIC HEALTH ISSUES

Bill/Author	Synopsis	SMS Position	Final Status
SB437 (Continued)	*All SMS opposed provisions were deleted from the bill prior to Senate action via a Goyke substitute amendment; SMS support was then offered. However, the Senate amended the Goyke substitute allowing for R.N. prescriptive privileges under protocol; SMS support was then dropped.		
Sexual Assault Examinations SB571/Legislative Council	Stipulates that no costs incurred by a hospital or by a physician for the examination of an alleged victim of sexual assault, when the examination is for the purpose of gathering evidence for possible prosecution, may be charged directly or indirectly to the alleged victim. Insurance carriers covering the victim are liable for the charges applicable to the terms of the policy; any portion not paid by the insurer must be paid by the county where the alleged assault was committed.	Monitor	Died in Human Services Committee.
Mumps Immunization **SB578/Law Revision Committee**	**Adds mumps to the state immunization program for school-age children.**	**Support**	**Law. (Chapter 257, Laws of 1981.)**
Child Seat Restraints SB673/Sen. Harsdorf (R-Beldenville)	Requires children under age four to be fastened in an approved seat restraint system while being transported in motor vehicles.	Support	Died in Aging, Business & Financial Institutions & Transportation Committee.
SB709/Sen. Berger (D-Milwaukee)	Requires children under age one to be fastened in an approved seat restraint system and children one to three to be fastened in a seat restraint or rear seat safety belt while being transported by state residents.	Support	Died in Aging, Business & Financial Institutions & Transportation Committee.
AB600/Rep. D. Travis (D-Madison)	**Requires children under age two to be fastened in an approved seat restraint system and children ages two and three to be fastened in a seat restraint or safety belt while being transported by their state-resident parents.**	**Support**	**Law. (Chapter 327, Laws of 1981.)**
Premarital VD Screening **AB66/Joint Finance Comm. (Biennial Budget Bill)**	**Repeals the requirement for a premarital examination for detection of veneral disease.**	**Support**	**Law. (Chapter 20, Laws of 1981.)**
Parental Notification AB207/Rep. Hopkins (R-Chippewa Falls)	Requires physicians to notify a minor's parents by certified mail at least 72 hours before performing an abortion on the minor.	Monitor	Died in Children & Human Development Committee.
AB714/Rep. Duren (D-Cazenovia)	Generally the same as AB207.	Monitor	Died in Children & Human Development Committee.
Adoption **AB246/Rep. Leopold (D-Milwaukee)**	**Establishes a system within the Department of Health and Social Services for the disclosure of information on an adopted child's birth parents and to conduct searches for birth parents at the child's request. Requires birth parents to file with the court certain medical information at the time of termination of parental rights. The court may order health care providers to release the medical information if the birth parents fail to comply. Requires notification of birth or adoptive parents on the existence of genetically transferable diseases.**	**Support**	**Law. (Chapter 359, Laws of 1981.)**
SB215/Sen. Adelman (D-New Berlin)	Same as AB 246.	Support	Died in Judiciary & Consumer Affairs Committee.

MEDICAL AND PUBLIC HEALTH ISSUES

Bill/Author	Synopsis	SMS Position	Final Status
Eye Enucleation AB653/Rep. Paulson (R-Amery)	**Allows persons acting under the direction of physicians or embalmers, who complete a course on eye enucleation and hold a certificate of competence from any approved medical school, to remove the eyes of deceased donors under the Uniform Anatomical Gift Act. Currently those persons may enucleate eyes only if they hold a certificate of competence from either of Wisconsin's medical schools.**	**Support**	**Law. (Chapter 290, Laws of 1981.)**
Choking Signs AB467/Rep. Menos (D-Glendale)	Requires the Department of Health and Social Services to distribute to restaurants a sign which details instructions explaining how to assist choking victims. Restaurants are required to post the signs.	Support	Died in Joint Finance Committee
AB496/Rep. Dorff (D-Kenosha)	Generally the same as AB467.	Support	Died in Health & Human Services Committee.
Local Health Agencies AB711/Health & Human Services Committee	**Makes various revisions to laws affecting local health agencies and communicable disease reporting.**	**Support**	**Law. (Chapter 291, Laws of 1981.)**
Elderly Abuse AB763/Rep. Rutkowski (D-Hales Corners)	Requires physicians and other health care providers to report abuse or neglect of the elderly, or of other people eligible for protective services, to the county public welfare or social services department.	Monitor	Tabled in Assembly.
AJR8/Rep. Tesmer (D-Milwaukee)	Directs the Legislative Council to study the problem of elderly abuse and report recommended solutions to the Legislature.	Monitor	Adopted.
Motorcycle Helmets AB831/Rep. Leopold (D-Milwaukee)	Reinstates the mandatory helmet law for persons riding motorcycles.	Support	Died in Highways Committee.
Informed Consent AB941/Rep. Nelson (Shorewood)	**Incorporates case law on informed consent into the statutes whereby physicians are required to inform patients about the availability of all alternate, viable medical modes of treatment and about the risks and benefits of those treatments. Failure to disclose relevant information is an allegation of unprofessional conduct.**	**Monitor**	**Law. (Chapter 375, Laws of 1981.)**
Lab Certification AB978/Rep. Robinson (D-Wausau)	Transfers the authority to certify laboratories that examine milk, water and food products from the Department of Health and Social Services to the Department of Agriculture, Trade & Consumer Protection.	Support	Died in Joint Finance Committee
Patient Rights AB1004/Rep. Clarenbach (D-Madison)	Creates a list of patient rights provisions required for all health care settings including: providing the patient with a written form, before services are rendered, indicating names and titles of persons rendering care, cost of the care, risks and benefits of the prescribed treatment, etc; allowing patients to revise their health care records; requiring providers to post patient rights signs and to distribute patient rights notices before providing treatment; and requiring providers to provide a list of patient advocates upon the patient's request.	Oppose	Died in Health & Human Services Committee.
Patient Records AB1080/Rep. Becker (D-Milwaukee)	Revises various aspects to the law on access to medical records, including limiting access by state and federal agencies to only specific medical record information authorized by statute, rule or regulation.	Support	Died in Health & Human Services Committee.

MEDICAL AND PUBLIC HEALTH ISSUES

Bill/Author	Synopsis	SMS Position	Final Status
AB1114/Rep. Thompson (R-Elroy)	Repeals the law allowing access to medical records by state and federal agencies. Presently government agencies have access unless the private-pay patient files a form within their medical records denying that access.	Support (SMS Bill)	Died in Health & Human Services Committee.
Public Health AB1107/Rep. Flintrop (D-Oshkosh)	Provides state funding to counties, cities and villages that establish a community public health services board. The board assumes all statutory public health functions currently assigned to the various local public health agencies.	Support (SMS Bill)	Died in Health & Human Services Committee.
AB1108/Rep. Flintrop (D-Oshkosh)	Divides the Division of Health within the Department of Health and Social Services into a Division of Public Health Administration and a Division on Health Regulation and Finance.	Support (SMS Bill)	Died in Health & Human Services Committee.
AJR100/Rep. Robinson (D-Wausau)	Requests a Legislative Council study on the existing public health system at the state and local level, including the consolidation of state agencies involved with public health.	Support (SMS Bill)	Died in Health & Human Services Committee.
Sexually Transmitted Diseases AB1128/Rep. Clarenbach (D-Madison)	Revises various laws regulating the control of sexually transmitted diseases, including requiring counties in which the incidence of gonorrhea or syphillis exceeds the statewide average to provide programs for diagnosis and treatment of those diseases at no cost to the patient, unless there is a public or private program already in operation.	Pending	Died in Health & Human Services Committee.

HEALTH INSURANCE

Bill/Author	Synopsis	SMS Position	Final Status
Kidney Disease & TB Coverage SB93/Sen. Kleczka (D-Milwaukee)	**Eliminates the required coverages for tuberculosis and kidney disease treatment. Presently health insurance policies which provide coverage for hospital treatment must cover inpatient and outpatient kidney disease treatment in an amount of not less than $30,000 annually, and a minimum 90 days continuous inpatient/outpatient coverage for tuberculosis treatment. (Kidney disease coverage was reinstated by Assembly amendment)**	**Oppose**	**Law. (Chapter 39, Laws of 1981.)**
Maternity Coverage SB201/Sen. Braun (D-Milwaukee)	**Requires group health insurance policies which provide coverage for dependent children and maternity coverage for any individual to also provide maternity coverage for dependent children.**	**Monitor**	**Law. (Chapter 99, Laws of 1981.)**
Chiropractor Disability Certification SB218/Sen. Berger (D-Milwaukee)	**Requires insurers to provide equal treatment of certification of disability whether signed by a chiropractor or a physician. Such certifications of disability are not required to be accepted as conclusive evidence of a disability.**	**Oppose**	**Law. (Chapter 55, Laws of 1981.)**
Optometry Insurance SB316/Insurance & Utilities Committee	**Prohibits insurers from refusing to provide coverage for vision care services or procedures provided by an optometrist, within the scope of optometric practice, if the contract or plan provides coverage for the same services or procedures when rendered by another health care provider. Applies only to contracts or plans covering vision care.**	**Oppose**	**Law. (Chapter 205, Laws of 1981.)**
AB413/Insurance, Cooperatives & Risk Management Committee	Same as SB316.	Oppose	Died in Joint Finance Committee.

HEALTH INSURANCE

Bill/Author	Synopsis	SMS Position	Final Status
AB940/Rep. Leopold (D-Milwaukee)	Same as SB316.	Oppose	Died in Joint Finance Comm.
Coverage Out-of-State SB381/Sen. Kreul (R-Fennimore)	**Prohibits health insurance exclusion or limitation of coverage in licensed or approved facilities outside Wisconsin, if the services are provided within 75 miles of the insured's residence.**	**Oppose**	**Law. (Chapter 304, Laws of 1981.)**
Continuation & Conversion Option SB516/Sen. Engeleiter (R-Brookfield)	Limits eligibility for group health continuation coverage to 30 days, and the election to convert to an individual policy must be made within that period. Employees who voluntarily terminate employment would no longer be eligible for the group health insurance continuation and conversion option. Under current law, members of group health insurance policies, their spouses, ex-spouses, and dependents are entitled to continue group health insurance coverage up to one year after that coverage would have otherwise terminated due to job termination, divorce, or death. That insurance can then be converted to an individual policy at premiums based at the standard risk applicable to the person's age and sex. This coverage is currently extended to employees who voluntarily terminate employment.	Oppose	Died in Insurance & Utilities Committee.
AB920/Rep. Munts (D-Madison)	Installs various revisions into the group health insurance continuation and conversion option law including: requires coverage of dependents of ex-spouses if they were covered under the original policy; exempts policies which cover only dental care, vision care or prescription drugs; allows for termination for persons establishing a residence outside the service area of an HMO; requires insurers to renew individual conversion policies; allows employers, rather than insurers, to require the insured to convert to an individual policy after one year of continued group coverage; and, allows group continuation policies to stipulate that premiums be paid directly to the insurer (presently employer must collect premium).	Support	Died in Health & Human Services Committee
Risk Sharing Plan SB528/Sen. McCallum (R-Fond du Lac)	Clarifies the extent of coverage for inpatient and outpatient treatment for nervous and mental disorders; alcoholism and drug abuse; home health care; skilled nursing care; and, out-of-state coverage for participants in the Wisconsin Health Insurance Risk-Sharing Plan.	Support	Passed Senate. Died in Insurance, Cooperatives & Risk Management Committee.
AB669/Rep. Munts (D-Madison)	**Same as SB528.**	**Support**	**Law. (Chapter 83, Laws of 1981.)**
Chiropractor Insurance SB603/Insurance & Utilities Committee	Requires health insurance policies to provide coverage for diagnosis and treatment of conditions and complaints performed within the scope of practice of a chiropractor, if the policy covers diagnosis or treatment of the condition or complaint when performed by a physician.	Oppose	Indefinitely postponed in Senate.
AB898/Rep. Hauke (D-West Allis)	Same as SB 603.	Oppose	Died in Joint Finance Committee.
Hospice Care SB733/Sen. Cullen (D-Janesville)	Requires health insurance policies to cover medical social services for the insured and members of the insured's family, if the insured was diagnosed by a physician as having a terminal condition. Bereavement assessment for the family is covered for up to three visits by a member of a hospice care team within one year after the death of the insured.	Oppose	Died in Insurance & Utilities Committee.

HEALTH INSURANCE

Bill/Author	Synopsis	SMS Position	Final Status
Claim Form Completion Charges AB226/Rep. Behnke (D-Milwaukee)	Prohibits anyone from imposing a fee for completing a health or disability insurance claim form used to enable the patient to receive his or her benefits.	Oppose	Died in Insurance, Cooperatives & Risk Management Committee.
Psychologist Insurance AB422/Rep. Clarenbach (D-Madison)	Prohibits health insurance policies from denying equal benefits for services rendered by a psychologist including consultation, diagnosis and treatment, if the same or similar services are covered under the policy when rendered by a physician.	Oppose	Died in Joint Finance Committee.
Medicare Supplement Policies AB489/Rep. Munts (D-Madison)	**Permits the Commissioner of Insurance to establish by rule minimum standards for Medicare supplement insurance policies. Without this legislation, each Medicare supplement insurance policy would need federal approval, effective January 1, 1982.**	**Support**	**Law. (Chapter 82, Laws of 1981.)**
Abortion Coverage AB628/Rep. Becker (D-Milwaukee)	Prohibits the state, counties or municipalities from covering elective abortions under health insurance plans offered to its employees.	Monitor	Died in Health & Human Services Committee.
AB302/Rep. Plewa (D-Milwaukee)	Contains provision identical to AB628.	Monitor	Died in Health & Human Services Committee.
SB370/Sen. Berger (D-Milwaukee)	Contains provision identical to AB628.	Monitor	Died in Human Services Committee.
Insulin Infusion Pumps AB703/Rep. Behnke (D-Milwaukee)	**Requires health insurance policies which provide coverage for expenses incurred for treatment of diabetes to provide coverage for expenses incurred by the installation and use of an insulin infusion pump or other equipment and supplies in the treatment of diabetes.**	**Monitor**	**Law. (Chapter 85, Laws of 1981.)**
AB1086/Rep. Behnke (D-Milwaukee)	**Incorporates the provisions of AB703 into the state health insurance plan covering state employees.**	**Monitor**	**Law. (Chapter 381, Laws of 1981). Veto overruled.**

DRUGS AND ALCOHOL

Bill/Author	Synopsis	SMS Position	Final Status
Drug Paraphernalia SB57/Sen. Lasee (R-DePere)	Creates restrictions on the sale, use, possession and advertising of drug paraphernalia. It is based on the Model Drug Paraphernalia Act (Drug Enforcement Administration of the Department of Justice) and placed in the Controlled Substances Act.	Support	Died in Human Services Committee.
SB119/Sen. Johnston (R-Fox Point)	Same as SB57.	Support	Died in Human Services Committee.
SB222/Sen. Goyke (D-Oshkosh)	Generally the same as SB57.	Support	Passed Senate. Died in Criminal Justice & Public Safety Committee.
AB55/Rep. Dorff (D-Kenosha)	Same as SB57.	Support	Died in Criminal Justice & Public Safety Committee.
AB58/Rep. Klicka (R-Wauwatosa)	Same as SB57.	Support	Died in Criminal Justice & Public Safety Committee.
AB260/Rep. Vanderperren (D-Green Bay)	Same as SB57.	Support	Died in Criminal Justice & Public Safety Committee.

DRUGS AND ALCOHOL

Bill/Author	Synopsis	SMS Position	Final Status
Controlled Substances SB98/Sen. Kleczka (D-Milwaukee)	**Specifies that chemical derivatives of the Schedule II drug methylphenidate be similarly regulated under the Controlled Substances Act. In addition, it specifies the chemical derivatives of the Schedule III drugs nalorphine and pentazocine be similarly regulated under the Controlled Substances Act.**	**Support**	**Law. (Chapter 6, Laws of 1981.)**
SB604/Sen. Kleczka (D-Milwaukee)	**Reschedules various drugs within the Controlled Substances Act including Talwin (pentazocine) from Schedule III to II, except 12.5 milligrams or less per dosage unit of Talwin compound remains in Schedule III.**	**Support**	**Law. (Chapter 205, Laws of 1981.)**
AB930/Rep. Prosser (R-Appleton)	**Requires the Controlled Substances Board to monitor the potential for diversion and actual diversion and to regularly report to state regulatory, licensing and law enforcement agencies. The Board is to enter into written agreements with state and federal agencies to ensure compliance with the Controlled Substances Law and to monitor cooperation between agencies.**	**Support**	**Law. (Chapter 200, Laws of 1981.)**
Optometrist DPA Use SB104/Sen. Opitz (R-Port Washington)	Repeals the July 1, 1982 sunset date on optometrists' authorization to use topical ocular diagnostic pharmaceutical agents, thereby making the authorization permanent.	Monitor	Died in Human Services Committee.
SB112/Human Services Comm.	**Same as SB 104.**	**Monitor**	**Law. (Chapter 15, Laws of 1981.)**
AB136/Rep. Barry (D-Mount Horeb)	Same as SB104.	Monitor	Tabled in Assembly.
Drinking Age SB159/Sen. Johnston (R-Fox Point)	Raises minimum drinking age to 19.	Support "21"	Died in Aging, Business and Financial Institutions, and Transportation Comm.
SB533/Sen. Cullen (D-Janesville)	Raises minimum drinking age to 19.	Support "21"	Died in Joint Finance Committee.
AB220/Rep. Ladwig (R-Racine)	Raises minimum drinking age to 19.	Support "21"	Died in Children & Human Development Committee.
AB229/Rep. Klicka (R-Wauwatosa	Raises minimum drinking age to 19.	Support "21"	Died in Children & Human Development Committee.
AB258/Rep. Vanderperren (D-Green Bay)	Raises minimum drinking age to 19.	Support "21"	Died in Children & Human Development Committee.
AB649/Rep. Alberts (R-Oconomowoc)	Raises minimum drinking age to 19.	Support "21"	Died in Children & Human Development Committee.
SB809/Sen. Harsdorf (R-Beldenville)	Raises minimum drinking age to 19 by raising age of majority to 19, voting privileges excepted.	Support "21"	Died in Labor, Government, Veterans Affairs & Tourism Comm.
SB829/Sen. Cullen (D-Janesville)	Raises minimum drinking age to 19, except high school graduates retain a minimum drinking age of 18.	Support "21"	Died in Aging, Business & Financial Institutions & Transportation.

DRUGS AND ALCOHOL

Bill/Author	Synopsis	SMS Position	Final Status
AB690/Rep. Medinger (D-LaCrosse)	Raises age for sale of beer and liquor for consumption and possession away from a licensed establishment to 19. Maintains age 18 for consumption in licensed establishments.	Support "21"	Died in Children & Human Development Committee.
SB220/Sen. Frank (D-Milwaukee)	Raises minimum drinking age to 21.	Support	Died in Aging, Business & Financial Institutions, & Transportation.
AB250/Rep. Duren (D-Cazenovia)	Raises minimum drinking age to 21.	Support	Died in Children & Human Development Committee.
Operating While Intoxicated (OWI) SB310/Sen. Adelman (D-New Berlin)	Strengthens the laws dealing with drunk driving. The bill's provisions include: an offense for operating a motor vehicle while having a blood or breath alcohol concentration of .1% or more is a separate offense from OWI; making OWI itself an act of negligence, thereby eliminating the state's burden of proving causal negligence; restricting plea bargaining for persons initially charged with OWI; requiring an assessment by an approved public treatment facility for persons convicted of OWI and for persons improperly refusing a chemical test, the assessment report may require treatment through s.51.42 and compliance with a driver safety plan; imposing a surcharge of $150 on OWI violations to fund assessment programs; increasing fines and jail time for OWI related violations.	Support	Died in Judiciary & Consumer Affairs Committee.
AB66/Joint Finance Comm. (Biennial Budget Bill)	**Same as SB310.**	**Support**	**Law. (Chapter 20, Laws of 1981.)**
SB445/Sen. Chilsen (R-Wausau)	Requires second-time OWI offenders within a five-year period to spend at least three days in jail. Presently those offenders have a five-day to six-month jail sentence; however, that penalty may be waived upon successful completion of an assessment and treatment program. (Chapter 20, Laws of 1981, stipulates that assessment and treatment can no longer be used to reduce jail time--five-days is mandatory for second time offenders within five years.)	Support	Died in Judiciary & Consumer Affairs Committee.
SB452/Sen. McCallum (R-Fond du Lac)	Requires a mandatory one-year license revocation for first-time conviction of OWI, two-years revocation for second OWI offense and revocation for life for third-time convictions. In addition, each offense has escalating fines, jail time and community service work.	Monitor	Died in Judiciary & Consumer Affairs Committee.
AB471/Rep. Jackamonis (D-Waukesha)	Makes OWI itself an act of negligence in cases involving injury or death, thereby eliminating the state's burden of proving causal negligence (Chapter 20, Laws of 1981 contains this provision.)	Support	Died in Judiciary Committee.
Look-Alike Drugs SB536/Sen. Goyke (D-Oshkosh)	**Prohibits the fraudulent advertising, and regulates the commercial trafficking, of substances that resemble controlled substances.**	**Support**	**Law. (Chapter 90, Laws of 1981.)**
Fetal Alcohol Syndrome SB627/Human Services Comm.	Requires the Department of Health and Social Services to distribute pamphlets describing the causes and effects of fetal alcohol syndrome to county clerks, who are then required to provide the pamphlets to marriage license applicants.	Monitor	Indefinitely postponed in Senate.

DRUGS AND ALCOHOL

Bill/Author	Synopsis	SMS Position	Final Status
Hypodermic Syringes AB564/Rep. Ulichny (D-Milwaukee)	Places hypodermic syringes in the same status as prescription drugs under the pharmacy laws. Possession without a prescription is prohibited, except for persons authorized to possess prescription drugs, embalmers, industrial users, and farmers.	Oppose	Died in Health & Human Services Committee.
Marijuana Decriminalization AB693/Rep. Clarenbach (D-Madison)	Decriminalizes possession or gift of 0.5 ounce or less of concentrated cannabis or 1.5 ounce or less of marijuana.	Oppose	Died in Criminal Justice & Public Safety Committee.
Therapeutic Marijuana AB697/Rep. Clarenbach (D-Madison)	**Creates a program within the Department of Health and Social Services to provide marijuana, or its derivatives, for medical purposes to patients suffering from glaucoma or the side effects of cancer chemotherapy or radiotherapy where the patient does not respond to or suffers severe side effects from conventional drugs. A Patient Qualification and Review Board is created to approve patients eligible to participate. (This bill was amended into acceptable form whereby the Controlled Substances Board is required to assist practitioners, who choose to prescribe marijuana, in the federal permit process necessary for receipt of the drug.)**	**Opposed Original Bill**	**Law. (Chapter 193, Laws of 1981.)**
Drug Administration in Schools AB728/Rep. Flintrop (D-Oshkosh)	Allows school employees or volunteers to administer prescription medications to pupils in compliance with written instructions of a practitioner if the pupil's parent consents in writing. Administration of over-the-counter drugs is authorized upon written instruction and consent of the pupil's parent.	Support	Passed Assembly. Died in Education & State Institutions Committee.
Prescription Labels AB803/Rep. Neubauer (D-Racine)	**Removes the requirement for a patient's address to appear on prescription labels.**	**Monitor**	**Law. (Chapter 230, Laws of 1981.)**
DMSO AJR44/Rep. Otte (D-Sheboygan)	Requests the University of Wisconsin to study the use of dimethyl sulfoxide for the treatment of arthritis.	Oppose	Died in Health & Human Services Committee.

ENVIRONMENTAL & OCCUPATIONAL HEALTH

Bill/Author	Synopsis	SMS Position	Final Status
Uranium Mining SB23/Sen. Cullen (D-Janesville)	Establishes a seven-year moratorium on uranium mining in Wisconsin.	Monitor	Died in Aging, Business & Financial Institutions & Transportation.
Smoking SB80/Sen. Risser (D-Madison)	Restricts smoking in certain public places and conveyances to designated areas.	Support	Passed Senate. Concurred in as amended by Assembly. Failed to receive final Senate action.
AB80/ Rep. Munts (D-Madison)	Same as AB80.	Support	Died in State Affairs Committee
Beverage Container Redemption SB172/Sen. Harnisch (D-Neillsville)	Requires a 10¢ minimum deposit on all metal, glass, and plastic soda and beer containers--refillable and non-refillable--sold in Wisconsin. Bans detachable pull tabs and plastic ring connectors.	Support	Died in Joint Finance Comm.
AB221/Rep. Munts (D-Madison)	Same as SB172.	Support	Died in Environmental Resources Committee.

ENVIRONMENTAL & OCCUPATIONAL HEALTH

Bill/Author	Synopsis	SMS Position	Final Status
2,4,5-T SB249/Sen. Adelman (D-New Berlin)	Bans the sale, distribution and use of the dioxin-containing herbicides 2,4,5-T and Silvex in Wisconsin.	Monitor	Died in Agriculture & Natural Resources Comm.
AB245/Rep. Loftus (D-Sun Prairie)	Same as SB 249.	Monitor	Died in Environmental Resources Committee.
Fireworks SB300/Sen. Risser (D-Madison)	Regulates the sale and possession of fireworks.	Monitor	Indefinitely postponed in Senate.
Nuclear Plants SB385/Sen. Strohl (D-Racine)	Prohibits until July 1, 1985, the construction of nuclear power plants and requires the PSC to conduct a study on nuclear power plants' economic feasibility.	Monitor	Died in Energy Committee.
AB344/Rep. Clarenbach (D-Madison)	Same as SB385.	Monitor	Died in Energy Committee.
AB915/Rep. Munts (D-Madison)	Requires utilities operating nuclear power plants to submit a decommissioning and high-level radioactive waste disposal financing plan to the PSC.	Monitor	Died in Joint Survey Committee on Tax Exemptions
Radioactive Waste Review Board SB412/Energy Committee	Creates a Radioactive Waste Review Board with responsibility to negotiate agreements with the federal government on all matters relating to the long-term disposal of high-level radioactive waste in Wisconsin.	Support	Died in Agriculture & Natural Resources Committee.
AB555/Environmental Resource Committee	Same as SB412.	Support	Law. (Chapter 62, Laws of 1981.)
Worker's Compensation SB625/Sen. Van Sistine (D-Green Bay)	Makes various revisions to the Worker's Compensation Act including: requires health care providers to release medical records of empolyee-related injuries to employees, employers, Worker's Compensation insurers, or to the Department of Industry, Labor, and Human Relations upon request; waives the right for an injured employee to refuse to submit to an examination over 100 miles from home if DILHR determines that circumstances warrant the examination; and, permits DILHR to appoint a health care provider to examine an employee if two or more providers have previously disagreed on the extent of the employee's disability or length of healing period.	Monitor	Law. (Chapter 92, Laws of 1981.)
AB430/Rep. Rooney (D-Racine)	Allows access to medical records without the patient's consent to the extent the records are needed for investigating, adjusting or settling claims for benefits under Worker's Compensation. (A similar provision was adopted in SB625).	Oppose	Died in Labor Committee.
AB867/Rep. Behnke (D-Milwaukee)	Permits injured employees to receive Worker's Compensation benefits beginning with the first calendar day the employee was absent from work as a result of the injury. Currently, payments are not made for the first three calendar days unless the disability still exists after seven days.	Monitor	Died in Labor Committee.
Noise Pollution SJR42/Sen. Flynn (D-West Allis)	Requires the Legislative Council to conduct a study of the need for noise pollution legislation with special consideration given to studying noise related to motor vehicles, aircraft and manufacturing plants and report its findings and recommendations to the 1983 Legislature.	Monitor	Adopted.

ENVIRONMENTAL & OCCUPATIONAL HEALTH

Bill/Author	Synopsis	SMS Position	Final Status
Ground Zero Week SJR49/Sen. Braun (D-Milwaukee)	Proclaims the week of April 18-24, 1982, Ground Zero Week in Wisconsin. The week is an opportunity for the public to focus on the issues presented by the nuclear arms race, including the medical consequences of a nuclear conflict.	Support	Adopted.
Occupational Disease Surveillance AB323/Legislative Council	Creates an Occupational Disease Surveillance System within the Department of Health and Social Services intended to improve the recognition of occupational diseases through the correlation of information on occupation with information on health effects. Requires occupational information on birth and death certificates, and in hospital records.	Support	Law. (Chapter 214, Laws of 1981.)
Phosphate Ban AB533/Rep. Munts (D-Madison)	Extends the ban on the sale of cleaning agents and chemical water conditioners containing phosphorus above certain levels from July 1, 1982, to July 1, 1984.	Monitor	Died in Environmental Resources Committee.
AB1064/Rep. Munts (D-Madison)	Extends the phosphate ban to July 1, 1987.	Monitor	Indefinitely postponed in Assembly.
Employee Right to Know AB615/Rep. Munts (D-Madison)	Requires employers to provide requesting employees and employee representatives written information regarding the identity and human health effects of toxic substances and infectious agents in the workplace. Contains a 30-year record retention requirement.	Monitor	Law. (Chapter 364, Laws of 1981.) Record retention vetoed.
Hazardous Wastes AB936/Environmental Resources Committee	Revises the laws on solid and hazardous waste management including: facility siting approval; review of waste facility license applications; proof of financial responsibility; and calls for a Legislative Council study on state groundwater management and a DNR study on hazardous waste disposal alternatives.	Support	Law. (Chapter 374, Laws of 1981.)
Safe Groundwater AB958/Environmental Resources Committee	Provides state agencies responsible for preventing water pollution with a coordinated groundwater protection program.	Support concept	Died in Environmental Resources Committee.

REGULATION & LICENSING

Bill/Author	Synopsis	SMS Position	Final Status
Professional Counselors SB275/Human Services Comm.	Creates within the Department of Regulation and Licensing a Professional Counselors Examining Board. Professional counselors must have a masters degree, or equivalent, and 1,250 hours of supervised experience to be licensed. Associate counselors must have a bachelor's degree and 1,250 hours of supervised experience to be certified.	Oppose	Died in Joint Finance Comm.
Athletic Trainers SB406/Sen. Cullen (D-Janesville)	Provides for the licensure of athletic trainers through the Medical Examining Board.	Oppose	Died in Human Services Committee.
Examining Board Functions SB446/Sen. Goyke (D-Oshkosh)	Allows each examining board under the Department of Regulation and Licensing to control its own staff and budgeting functions. Ninety percent of all revenues collected by each examining board would be retained by the examining board; the remainder goes into the general fund.	Support concept	Died in State & Local Affairs & Taxation Comm.
AB609/Rep. Barczak (D-West Allis)	Same as SB446.	Support concept	Died in Commerce & Consumer Affairs Committee.

REGULATION & LICENSING

Bill/Author	Synopsis	SMS Position	Final Status
AB878/Joint Legislative Audit Committee	Transfers examination, licensure, and administrative rule functions from examining boards to the Department of Regulation & Licensing. (Model Board Bill)	Oppose	Died in Commerce & Consumer Affairs Committee.
AB15/Rep. Gerlach (D-South Milwaukee)	**Incorporates the provisions of AB878, but applies only to the Real Estate Board.**	**Monitor**	**Law. (Chapter 94, Laws of 1981.)**
Record Inspection SB467/Joint Committee for Review of Administrative Rules	Requires the Department of Regulation and Licensing or its attached examining boards to promptly notify a licensee in writing of any person seeking to copy or obtain information from any record of the licensee.	Oppose	Motion to reconsider passage vote tabled in Senate.
State Agency Sunset SB470/Sen. Cullen (D-Janesville)	Establishes a schedule for "sunsetting" state executive agencies, including the Medical Examining Board, unless recreated by the Legislature.	Oppose	Died in Joint Finance Committee.
Canadian Physician SB634/Sen. George (D-Milwaukee)	Requires the Medical Examining Board to grant an unrestricted license without further examination, and without any requirement of reciprocity, to any person who is registered on the Canadian medical register as a licentiate of the Medical Council of Canada and who has practiced medicine and surgery in Wisconsin for at least two years under any class of license. (This legislation applies to one specific physician who has thus far been unable to meet existing licensing standards in Wisconsin.)	Oppose	Died in Human Services Committee
AB383/Rep. Menos (D-Glendale)	Same as SB634.	Oppose	Died in Health & Human Services Committee.
DOJ Attorneys AB66/Joint Finance Comm. (Biennial Budget Bill)	**Requires the Department of Regulation and Licensing to provide legal services to the examining boards. Previously Department of Justice attorneys acted as legal advisers to the boards.**	**Monitor**	**Law. (Chapter 20, Laws of 1981.)**
DRL Elimination SB667/Sen. Kreul (R-Fennimore)	Eliminates the Department of Regulation and Licensing on July 1, 1982, and transfers all functions and duties to the Department of Agriculture, Trade and Consumer Protection.	Monitor	Died in State & Local Affairs, & Taxation Comm.
Temporary Licenses AB710/Health & Human Services Committee	Authorizes the Department of Regulation and Licensing, rather than the Medical Examining Board, to issue temporary physician licenses.	Oppose	Tabled in Assembly.

HOSPITALS

Bill/Author	Synopsis	SMS Position	Final Status
Hospital Reporting SB68/Joint Committee for Review of Administrative Rules	**Requires hospitals to report peer investigation information to the Medical Examining Board which results in the loss or reduction of a physician's hospital staff privileges for 30 days or more, or which results in a physician resigning from the staff for 30 days or more.**	**Support**	**Law. (Chapter 135, Laws of 1981.)**
AB157/Joint Committee for Review of Administrative Rules	Same as SB 68.	Support	Died in Rules Committee.
Public Hospital Abortions SB370/Sen. Berger (D-Milwaukee)	Prohibits government-owned hospitals and facilities from performing abortions, except to prevent the death of the mother.	Monitor	Died in Human Services Committee.
AB302/Rep. Plewa (D-Milwaukee)	Same as SB370.	Monitor	Died in Health & Human Services Committee.

HOSPITALS

Bill/Author	Synopsis	SMS Position	Final Status
AB621/Rep. Becker (D-Milwaukee)	Same as SB370, except first and second-trimester abortions are authorized if the pregnancy is due to sexual assault or incest; if the abortion is to prevent grave, long-lasting physical health damage to the woman due to a pre-existing medical condition; and if a diagnostic study shows the fetus to be affected by a severe genetic or detectable developmental disorder.	Monitor	Passed Assembly. Died in Human Services Committee.
Hospital Rate Review SB388/Joint Committee on Legislative Audit	Eliminates the Wisconsin Hospital Rate Review Program and establishes a Hospital Cost Containment Program Administered by the Department of Health and Social Services to prospectively set mandatory hospital rates.	Oppose	Died in Judiciary & Consumer Affairs Committee.
AB474/Joint Committee on Legislative Audit	Same as SB388.	Oppose	Died in Health & Human Services Committee.
SB390/Joint Committee on Legislative Audit	Renames the Hospital Rate Review Program to Hospital Cost Containment Program and requires half the appointees to committees established under that program to be selected through a process involving state participation.	Oppose	Died in Judiciary & Consumer Affairs Committee.
AB476/Joint Committee on Legislative Audit	Same as SB390.	Oppose	Died in Health & Human Services Committee.
SB605/Sen. Adelman (D-New Berlin)	Repeals DHSS's authority to participate in Wisconsin's Hospital Rate Review Program with the Wisconsin Hospital Association and Blue Cross. Instead, DHSS is given authority to establish mandatory prospective hospital rates on its own. Certificate of need is tied in with the rate-setting procedure when the CON is based on projected occupancy levels. Cost overruns or lower than expected occupancy levels may not be a basis for charging increased rates.	Oppose	Died in Judiciary & Consumer Affairs Committee.
AB822/Rep. Wagner (D-Salem)	Same as SB605.	Oppose	Died in Health & Human Services Committee.
AB365/Rep. Gerlach (D-South Milwaukee)	**Revises the appointment procedure for the Rate Review Committee and the Standards Development Committee established under Wisconsin's Hospital Rate Review Program.**	**Monitor**	**Law.(Chapter 323, Laws of 1981.)**
Smoking in Hospitals SB421/Sen. Lasee (R-DePere)	Prohibits smoking in hospitals.	Monitor	Died in Human Services Committee.
Public Patient Treatment AB66/Joint Finance Committee (Biennial Budget Bill)	Extends the public patient treatment program to residents of Milwaukee County, and allows Milwaukee County Hospital to treat public patients under the same arrangement extended to University Hospital and Clinics. Presently, individuals without financial means to support their own care must be referred to UW Hospital & Clinics with the state funding 50% of treatment costs and the county where the patient resides funding the other 50%.	Monitor	Vetoed.
AB329/Rep. Becker (D-Milwaukee)	Same as AB66 provision.	Monitor	Died in Health & Human Services Committee.

HOSPITALS

Bill/Author	Synopsis	SMS Position	Final Status
SB583/Sen. Braun (D-Milwaukee)	Permits county hospitals (including Milwaukee County Hospital) and hospitals under contract with counties to treat public patients at 50% state reimbursement and 50% reimbursement from the county where the patient resides. Milwaukee County residents continue to be ineligible. Presently treatment must be provided by UW Hospital and Clinics to receive the 50% state match.	Monitor	Died in Human Services Committee.
Chiropractor Referral SB632/Senate Human Services Committee	Requires hospitals to provide outpatient diagnostic x-ray and laboratory services to patients referred by chiropractors. Hospitals are required to provide reports on the results of the diagnostic procedure ordered to the referring chiropractor.	Oppose	Died in Human Services Committee.
AB882/Rep. Becker (D-Milwaukee)	Same as SB632.	Oppose	Died in Rules Committee.
Medicaid Rate Nov. SSSB1/Senate Organization Committee (Budget Repair Bill)	**Requires Medicaid daily rate reimbursement to hospitals be based on the adjusted state skilled nursing facility rate if DHSS determines that continued hospitalization is no longer necessary or appropriate during the period the recipient awaits nursing home placement.**	**Monitor**	**Law. (Chapter 93, Laws of 1981.)**
Outpatient Services Nov. SSSB1/Senate Organization Committee (Budget Repair Bill)	**Prohibits Medicaid reimbursement for outpatient hospital services from exceeding reimbursement for comparable services performed by providers not owned or operated by hospitals.**	**Oppose**	**Law. (Chapter 93, Laws of 1981.)**
CON Moratorium AB66/Joint Finance Comm. (Biennial Budget Bill)	**Prohibits acceptance of Certificate of Need applications—not completed before May 1, 1981—until July 1, 1983, for hospital capital expenditures exceeding $1 million and for nursing home capital expenditures. DHSS is required to submit a post-moratorium planning system to the Legislature prior to February 1, 1983.**	**Oppose**	**Law. (Chapter 20, Laws of 1981.)**
CON Minimums AB66/Joint Finance Comm. (Biennial Budget Bill)	**Increases capital expenditure minimums requiring a Certificate of Need from $117,000 to $150,000 for a single piece of clinical equipment and for health-related capital expenditures, and increases from $150,000 to $164,000 for two or more pieces of clinical equipment and for non-health-related capital expenditures.**	**Support**	**Law. (Chapter 20, Laws of 1981.)**
Decertification AB66/Joint Finance Comm. (Biennial Budget Bill)	**Repeals DHSS authority to decertify specialized hospital services.**	**Support**	**Law. (Chapter 20, Laws of 1981.)**
Education & Research AB66/Joint Finance Comm. (Biennial Budget Bill)	**Disallows education and research cost not directly involved in patient care in determination of a hospital's Medicaid reimbursement. DHSS is to determine the method and submit to the Joint Finance Committee for approval.**	**Oppose**	**Law. (Chapter 20, Laws of 1981.)**
Ambulatory Surgery AB66/Joint Finance Comm. (Biennial Budget Bill)	**Requires Medicaid procedures performed on an inpatient basis that could be performed on an outpatient basis to be reimbursed at the outpatient rate. DHSS to determine procedures and criteria.**	**Oppose**	**Law. (Chapter 20, Laws of 1981.)**
Hospital Collective Bargaining AB371/Rep. Becker (D-Milwaukee)	**Reduces payments to hospitals that employ persons to defeat organization of a hospital employee's union. Rate review is required to reduce rates by a proportionate amount necessary to offset such hospital expenditures.**	**Oppose**	**Law. (Chapter 361, Laws of 1981.)**

HOSPITALS

Bill/Author	Synopsis	SMS Position	Final Status
Philanthropic Gifts AB597/Rep. Helbach (D-Stevens Point)	Prohibits Rate Review from requiring that a hospital use philanthropic gifts to reduce operating expenses or to offset revenue requirements in the determination of hospital rates.	Support	Died in Joint Finance Committee.
CON Bidding AB912/Rep. Loftus (D-Sun Prairie)	Requires health care institutions, that receive a Certificate of Need for the construction or physical alteration of the institution, to contract for the completion of the project by competetive bidding.	Monitor	Died in Health & Human Services Committee.

MENTAL HEALTH

Bill/Author	Synopsis	SMS Position	Final Status
Mental Health Institutes SB100/Sen. Goyke (D-Oshkosh)	Prohibits the State Building Commission from authorizing any part of a mental health institute for use as an adult correctional facility.	Support	Died in Education & State Institutions Comm.
AB66/Joint Finance Comm. (Biennial Budget Bill)	Same as SB100.	Support	Vetoed.
S.51.42 Treatment Directors SB207/Sen. Engeleiter (R-Brookfield)	Allows community mental hygiene boards (s.51.42 Boards) to appoint a clinical pyschologist as director of clinical treatment programs. Presently, the director is required to be a psychiatrist.	Oppose	Died in Human Services Committee
AB519/Rep. Jackamonis (D-Waukesha)	Same as SB207.	Oppose	Died in Local Affairs Committee.
Minor Commitment SB456/Sen. Van Sistine (D-Green Bay)	Raises age limit from 14 to 16 for a minor's consent to voluntary admission to an inpatient facility for treatment of mental illness, developmental disability, alcoholism, or drug abuse--thereby allowing for parental involvement in the commitment process for minor's under 16.	Support	Died in Human Services Committee
T-19 Psychotherapy AB66/Joint Finance Comm. (Biennial Budget Bill)	**Repeals coverage of outpatient psychotherapy under Medicaid by virtue of the Governor's veto.**	**Oppose**	**Law. (Chapter 20, Laws of 1981.)**
Nov. SSB1/Senate Organization Committee (Budget Repair Bill)	**Reinstates outpatient psychotherapy services to the extent they be rendered by the s.51.42 Board in the county where the patient resides including outpatient services provided by a psychiatrist. The s.51.42 Board is liable for 10% of the rate established by DHSS for these services. The original bill provided Medicaid coverage for services rendered directly by psychiatrist, but it was deleted by the Joint Finance Committee.**	**Monitor**	**Law. (Chapter 93, Laws of 1981.)**
Length of Stay AB66/Joint Finance Comm. (Biennial Budget Bill)	**Reduces from 28 to 21 days the allowable length of stay for inpatient mental health treatment under s.51.42. The Department may withhold a portion of the Board appropriation if treatment exceeds 21 days.**	**Monitor**	**Law. (Chapter 20, Laws of 1981.)**
Outpatient Insurance AB66/Joint Finance Comm. (Biennial Budget Bill)	Increases from $500 to $1,000 the required insurance coverage for outpatient mental health, alcoholism and other drug abuse treatment.	Support	Vetoed.
Commitment Standards AB262/Rep. Schneider (D-Wisconsin Rapids)	Amends the standards for emergency detention and involuntary commitment. The standard of dangerousness for inability to satisfy basic needs is changed from "substantial probability" to "reasonable possibility." Recent acts or omissions under that standard are defined as those occurring within 180 days prior to being taken into custody.	Support	Died in Health & Human Services Committee.

MENTAL HEALTH

Bill/Author	Synopsis	SMS Position	Final Status
Criminal Competency AB607/Rep. Becker (D-Milwaukee)	Permits a Court to appoint a licensed psychologist (present law requires one or more physicians) to examine a defendant in competency to stand trial proceedings or in proceedings where a defendant pleads not guilty by reason of mental disease or defect.	Oppose	Assembly amended from bill.
AB765/Rep. Rutkowski (D-Hales Corners)	**Same as AB607. However, the provision was amended to allow the Court to appoint one or more examiners having the specialized knowledge determined by the Court to be appropriate to examine and report upon the condition of the defendant.**	**Oppose**	**Law. (Chapter 367, Laws of 1981.)**
S.51.42 Membership AB1006/Rep. Munts (D-Madison)	Requires at least one-third of s.51.42 Board members appointed after January 1, 1983 to be individuals who have received services for mental illness, alcoholism or drug dependence, or their family members, or representatives of advocacy groups. Prohibits membership for persons having financial interests with provider services to counties or officers, directors, employees or family members of public or private providers of services.	Oppose	Died in Rules Committee.

TITLE XIX - MEDICAID

Bill/Author	Synopsis	SMS Position	Final Status
Abortion Funding SB762/Human Services Comm.	Expands the situations where public funding may pay for an abortion including: if the abortion is performed on a child 15 or under; if the woman has a pre-existing mental illness; and if a test shows the fetus to be affected by a severe genetic or developmental disorder.	Monitor	Died in Human Services Committe
AB410/Rep. Clarenbach (D-Madison)	Repeals the prohibition against state or local funding for nontherapeutic abortions.	Monitor	Died in Health & Human Services Committee.
Second Opinions SB763/Sen. Offner (D-LaCrosse)	Extends the termination date for the Second Opinion Program from June 30, 1982 to June 30, 1984.	Support	Died in Joint Finance Committee.
SB783/Joint Finance Comm. (Budget Repair Bill)	**Makes the Second Opinion Program permanent.**	**Oppose**	**Law. (Chapter 317, Laws of 1981.)**
AB553/Rep. Donoghue (R-Merrill)	Repeals the Second Opinion Program.	Support	Died in Health & Human Services Committee.
Artificial Insemination SB783/Joint Finance Comm. (Budget Repair Bill)	Subjects physicians to unprofessional conduct charges and disciplinary action by the Medical Examining Board for providing artificial insemination to a woman, who the physician knows, or has reason to believe is receiving AFDC or Medicaid or who will be eligible for those benefits as a result of the child's birth.	Oppose	Vetoed.
Nursing Pools AB16/Rep. Leopold (D-Milwaukee)	Requires DHSS to establish Medicaid reimbursement maximum rate for services provided by nursing pools not to exceed 110% of the prevailing wage and fringe benefit rate for the same services provided by nurses in the same geographic area.	Monitor	Died in Health & Human Services Committee.
Preadmission Screening AB64/Rep. Leopold (D-Milwaukee)	Establishes a method of screening persons covered by Medicaid who seek admission to nursing homes, to ensure that nursing home care is appropriate.	Monitor	Died in Health & Human Services Committee.

TITLE XIX - MEDICAID

Bill/Author	Synopsis	SMS Position	Final Status
Community Options Program AB66/Joint Finance Comm. (Biennial Budget Bill)	**Requires Medicaid-eligible persons seeking admission to nursing homes to undergo assessments for evaluating feasibility of altemative community support services in lieu of nursing home care. An assessment determination that nursing home care is not appropriate supercedes a physician's plan of care authorizing nursing home care if the determination includes review by a physician. Eight counties may elect to participate in the program beginning in January 1, 1982. As of January 1, 1983 additional counties with a total of 70% of the state's nursing home population are required to participate. Assessment is a requirement of Medicaid nursing home reimbursement.**	**Monitor**	**Law. (Chapter 20, Laws of 1981.)**
Provider Contracts AB66/Joint Finance Comm. (Biennial Budget Bill)	**Allows DHSS to enter into Medicaid contracts with providers who donate their services at no charge or who provide services for reduced payments.**	**Monitor**	**Law. (Chapter 20, Laws of 1981.)**
Podiatric Procedures AB66/Joint Finance Comm. (Biennial Budget Bill)	**Allows DHSS to establish a reasonable charge for surgical procedures performed by physicians that are within the scope of podiatric practice. (This provision was inserted due to podiatrists' elimination from Medicaid.)**	**Oppose**	**Law. (Chapter 20, Laws of 1981.)**
T-19 Study AB66/Joint Finance Comm. (Biennial Budget Bill)	**Requires the Legislative Council to study Medicaid and recommend altematives to reduce the state's long-range financial commitment to the program. The study shall include: modifications in coverage of optional and mandated services; expansion of the role of nongovernment health insurers; and mechanisms for providing a more cost-effective, market-oriented health care delivery system, such as publishing price information. Findings are to be reported to the Govemor and Legislature prior to January 1, 1983.**	**Monitor**	**Law. (Chapter 20, Laws of 1981.)**
Child Liability AB217/Rep. Stitt (R-Port Washington)	Requires children over 18 to contribute to a parent's nursing home care if the parent would be eligible for Medical Assistance without the child's support. Establishes an ascending scale of the child's maximum liability per day--$3.25 at an income of $30,000 all the way to the entire cost of care at an income above $115,000. A federal waiver to implement this law is required.	Monitor	Died in Aging, Women & Minorities Committee.
Independent Living Centers AB846/Rep. Plous (D-Milwaukee)	Allows independent living centers to be certified as Medicaid providers and to receive payment for up to three hours per day of personal care to recipients who left a nursing home after being evaluated as appropriate for nursing care, but able to live outside an institution with some additional care.	Monitor	Died in Joint Finance Committee.
Wrongful Aid AB992/Rep. Holschbach (D-Manitowoc)	Allows counties that assist in recovering incorrect Medicaid payments due to error or fraud by a recipient or a provider to retain 25% of the recovered funds. (Chapter 317, Laws of 1981, contains similar provision)	Monitor	Died in Local Affairs Committee.
Podiatrists AB66/Joint Finance Comm. (Biennial Budget Bill)	**Repeals coverage of podiatric services by virtue of the Governor's veto.**	**Monitor**	**Law. (Chapter 20, Laws of 1981.)**
AB1032/Rep. Behnke (D-Milwaukee)	Restores Medicaid coverage for podiatric services.	Monitor	Died in Joint Finance Committee.
Drug Coverage AB1052/Rep. Swoboda (D-Luxemburg)	Expands Medicaid coverage of all legend drugs for the medically indigent. Currently, coverage for all legend drugs is extended only to the categorically needy.	Monitor	Died in Joint Finance Committee.

MEDICAL LIABILITY

Bill/Author	Synopsis	SMS Position	Final Status
WHCLIP Revisions SB628/Insurance & Utilities Committee	Allows the Wisconsin Health Care Liability Insurance Plan's Board of Governors to refund surpluses in the Plan or to deplete surpluses by prospective rate reduction. Present law allows only rate reduction. Establishes a dissolution clause whereby any excess assets in the Plan revert to the state general fund.	Support	Passed Senate. Died in Assembly Insurance, Cooperatives & Risk Management Committee.
Panel Revisions AB537/Rep. Hauke (D-West Allis)	Makes various changes to the Patients Compensation Panels including: claims ceiling heard by informal panels is increased from $10,000 to $25,000; restricts recovery to $25,000 if initial claim is less than $25,000; increases per diems for all panel members from $75 to $125; allows establishment of sufficient number of formal panels to handle the caseload (presently limited to four panels). Many of AB 537's provisions were incorporated in SB628 prior to Senate passage.	Support	Passed Assembly. Died in Joint Finance Committee.
Fund **AB66/Joint Finance Comm. (Biennial Budget Bill)**	**Requires the Legislative Audit Bureau to perform a financial audit on the Patient's Compensation Fund during the 1981-83 biennium, and at least once every three years thereafter.**	**Monitor**	**Law. (Chapter 20, Laws of 1981.)**
Wrongful Life AB629/Rep. Becker (D-Milwaukee)	Prohibits suits based on wrongful life/birth.	Monitor.	Died in Health & Human Services Committee.

HEALTH EDUCATION

Author/Bill	Synopsis	SMS Position	Final Status
Dogs for Research SB518/Sen. Engeleiter (R-Brookfield)	Requires humane officers or dog pounds to release unclaimed dogs to the University of Wisconsin System or the Medical College of Wisconsin upon requisition in writing by those institutions. Presently, unclaimed dog release is optional.	Support	Returned to Author.
Loan Repayment Program SB796/Sen. Offner (D-LaCrosse)	Provides grants of up to $40,000 over a four-year period for primary care physicians establishing a practice in a DHSS-designated underserved area of Wisconsin. Replaces the Medical School Loan and Forgiveness Program.	Pending	Died in Human Services Committee.
Paramedics Gov. SSB1/Senate Organization Committee (Budget Repair Bill)	Requires the UW Medical School to develop a textbook appropriate for use in the training of paramedics.	Monitor	Vetoed.
HEAL Program **AB66/Joint Finance Comm. (Biennial Budget Bill)**	**Requires medical school students and residents to pay 3% annual interest on Wisconsin Health Education Loans. Previously, all interest was deferred until after residency training. Requires federal approval.**	**Monitor**	**Law. (Chapter 20, Laws of 1981.)**
Physician Study **AB66/Joint Finance Comm. (Biennial Budget Bill)**	**Requires the Department of Health & Social Services to study the projected need for physicians in Wisconsin, by type and specialty, by the year 2000 and the level of enrollments at the two medical schools which will be required to meet the projected need.**	**Monitor**	**Law. (Chapter 20, Laws of 1981.)**
Family Practice **AB66/Joint Finance Comm. (Biennial Budget Bill)**	**Increases Department of Family Medicine & Practice appropriation by $598,000 to assure continuance of the Wausau and Eau Claire programs. (SMS and the Department of Family Practice jointly requested this amendment to the Budget.)**	**Support**	**Law. (Chapter 20, Laws of 1981.)**

HEALTH EDUCATION

Bill/Author	Synopsis	SMS Position	Final Status
AB66/Joint Finance Comm. (Biennial Budget Bill)	**Requires the Department of Family Medicine & Practice to include in its 1983-85 budget request recommendations which will permit its residency program to continue operations at the current funding levels.**	**Monitor**	**Law. (Chapter 20, Laws of 1981.)**
Medical Records AB725/Rep. Behnke (D-Milwaukee)	Repeals the law authorizing access to patient health care records, without informed consent, for medical research purposes.	Oppose	Died in Health & Human Services Committee.

MISCELLANEOUS ISSUES

Bill/Author	Synopsis	SMS Position	Final Status
Emergency Services SB259/Sen. Cullen (D-Janesville)	Allows a person trained in advanced first aid, according to standards of the American National Red Cross, to substitute as one of the required ambulance attendants in municipalities under 15,000. Current law requires at least two licensed ambulance attendants, paramedics, registered nurses, physicians assistants or physicians, or any combination thereof to be present on ambulance runs.	Support	Died in Human Services Comm.
SB282/Sen. Theno (R-Ashland)	**Allows ambulance drivers, who are not licensed ambulance attendants, to assist in handling or moving the patient under the supervision of a licensed attendant. Continues to prohibit the driver from rendering emergency care procedures.**	**Support**	**Law. (Chapter 73, Laws of 1981.)**
Tax Exemptions SB736/Sen. Bablitch (D-Stevens Point)	Creates a state income tax credit equal to 50% of the purchase price of child seat restraint systems.	Monitor	Died in State & Local Affairs & Taxation Committee
AB69/Rep. Tesmer (D-Milwaukee)	Exempts alcohol, cotton, needles, tape and other supplies bought by a person for the treatment of diabetes from the sales tax.	Monitor	Died in Joint Survey Committee on Tax Exemptions.
AB439/Rep. Matty (R-Crivitz)	Exempts medical equipment that is durable and disposable and sold for personal use from the sales tax.	Monitor	Died in Joint Survey Committee on Tax Exemptions.
AB577/Rep. Czarnezki (D-Milwaukee)	Eliminates the income tax deduction for any medical expense related to abortion.	Monitor	Died in Joint Survey Comm. on Tax Exemptions.
AB636/Rep. Broydrick (D-Milwaukee)	Creates an income tax deduction, available to persons who itemize deductions, for the fair market value of blood donated to tax-exempt organizations.	Monitor	Died in Joint Survey Committee on Tax Exemptions.
AB985/Rep. Shoemaker (D-Menomonie)	Grants a property tax exemption for all medical and health care equipment held by business for short-term rental.	Monitor	Died in Joint Finance Committee.
Nutrition AB67/Rep. Tesmer (D-Milwaukee)	Requires nutrition be taught in 7th, 8th, or 9th grade in all public schools either as a separate course or as one-third of an existing health course.	Monitor	Died in Education Committee.
Food Product Donors AB590/Rep. Becker (D-Milwaukee)	**Excepts from civil liability persons who donate, or sell at cost, food products to charitable organizations and to charitable organizations which distribute the food products free of charge.**	**Support**	**Law. (Chapter 219, Laws of 1981.)■**

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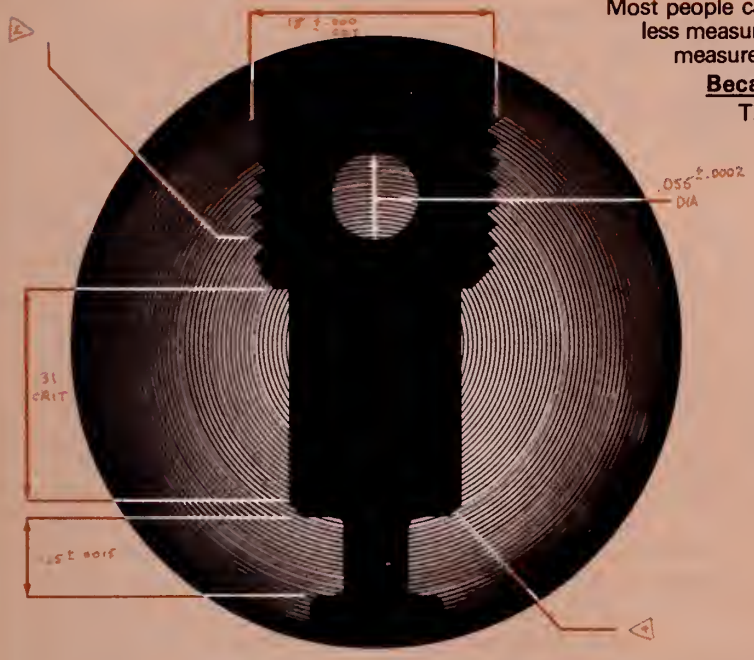

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Special

Medical marketing: Here to stay?

Consider these facts:

- *Today, seventy-five cents of every dollar earned or spent is derived from the sale or purchase of services, not products. In 1974 less than fifty cents of each dollar was spent on services.*
- *During the coming decade the age 40 and older population will expand seven times faster than the average of the prior 50 years.*
- *During the period 1974-1978, the general population increased by only 3.4% while the number of patient care physicians increased by 13.3%.*
- *Since 1960, the average age at which a woman conceives her first child has risen by almost five years. The number of childless couples under age 40 has increased by 25%.*
- *In 1950, 78% of all the household units were designated families based upon the definition: an adult male and female, only one employed partner and one or more children under age 18. By that same definition, in 1977 just 7% of all household units were families for a total decline of 71% in 27 years.*

So what, you say? Well figures such as these could have significant impact on physicians and how they practice medicine during the coming decade, according to a medical marketer.

To take a close look at the phenomenon known as "medical marketing," SMS Communications Coordinator Diane Upton recently interviewed marketing communications specialist Alan Gaudynski, vice president of Zigman-Joseph-Skeen, Consultants in Public Relations and Marketing. Mr Gaudynski has held development and communications positions at two major Wisconsin hospitals and presently provides marketing communications counsel to numerous medical and healthcare organizations in the Midwest.

Question: When you say the word "marketing" to physicians, it automatically conjures up images of advertising, solicitation, publicity, and commercialism. Marketing, too often, implies giving away toasters at a savings and loan institution. Historically, the medical profession has considered it unethical and unprofessional for physicians to solicit patients. They believe their work should stand on its own merits. Why should this change, what can marketing offer physicians, and, more importantly, what can it offer their patients?

Answer: I think physicians have only seen and reacted to the visable parts of marketing—things like the advertising or the promotional aspects of marketing. But really those aspects are a very small percentage of what marketing is. Marketing is a human science that studies human behavior and reactions to the four Ps: product, price, place, and promotion. We have to change those four Ps for a service organization such as a medical practice. Product becomes service, price becomes cost. There are many factors involved with cost. There's a psychological factor: it's something that I have to give up, either money, time, health, whatever it is. Place is important, that is, access to any kind of service. Marketing studies place. It studies transportation, parking, and buslines. It studies whether people use foot transportation, walking to a service or where a product is available, or if they get on buses or get in cars and so on. Promotion is really a very small aspect of it. In medical marketing, promotion or service information has been very weak. It's been the weakest part of all the four Ps. The medical profession has always been weak in providing information *before* the patient needs the service. Patients are saying I want more information to make a choice before I need the service, so I know where to go before I need it. The medical community has been reluctant to help provide them with the information for them to make the choice.

Question: Won't this conflict with medical ethics, which discourage direct solicitation of patients?

Answer: I see no conflict between medical ethics and the use of proper marketing principles. Government and consumer groups have already encouraged physicians to improve their marketing and communication skills. We see this in the Federal Trade Commission suit with the AMA about advertising standards and the Supreme Court decision okaying lawyer ads that are not misleading. Many professions already utilizing marketing principles provide the consumer with a free first visit. Most law firms and marketing/public relations firms and many accounting firms do this.

In this instance the potential buyer of the service can make the choice based on fact and not on what a neighbor says or what a co-worker says, when they move into the area, about Doctor So-and-So is a good doctor because he/she smiles, dresses well or has a charming personality. Perhaps the first visit could be free so that the patient could determine whether that is the physician for his or her particular need. Then the patient, in that respect, is doing his or her own market research.

Question: You keep referring to buying services. You infer that you can market healthcare like you market a shirt, and certainly there's a difference there.

Answer: Well, there's a big difference but one of the main differences is the study of human behavior. The shirt manufacturers for years have been studying human behavior in the buying patterns of people who want and need shirts. Unfortunately, again the medical community has not been patient-oriented in studying what the patient wants and needs from a medical professional. For example, in the Midwest and especially on the east and west coasts there are many 24-hour, free-standing, outpatient ambulatory and emergency care facilities. These facilities are springing up because there is an unfilled patient marketing need—many people feel that they can't get to their own family physician or primary care provider on evenings or weekends. Very few people have done any market research to find out what the potential patients of an organization want and expect from a physician. Many people would like to see physicians have evening hours. With one of our clients right now we're working with an evening clinic of three hours a week, one evening a week. It's a women's clinic and it's filled every week because that's what the buyers of the service wanted. They couldn't get to that organization's medical facility during the day because they were either at home with children or at work and now through the marketing process, an evening clinic has evolved. The medical profession has got to do more of this buyer research and determine what they want. That's the whole marketing orientation: what does the patient want? Not, what does the doctor want?

Question: Will it be possible to separate the business from the profession once that's done?

Answer: I think they have to go hand in hand. One of the weaknesses of the medical profession is that it has not utilized many business management practices. If you take a look at the medical practices that are declining in utilization in the state and you would do some market research, I think you would find out that they aren't employing accepted business procedures such as marketing in their medical practice.

Question: A consultant who analyzes trends in medical care delivery has made some statement about the future of medicine and particularly about group practice. He says the future is quite certain for the group practice in this nation. Physicians' incomes will not keep pace with inflation. Competition among doctors, delivery systems, and allied health personnel will become far more intense. Increasing fees to cover higher overhead costs will not be possible. Taxes will continue to rise and government regulation is likely to expand into the ambulatory care sector. He says that unless group practices begin to adopt an operational philosophy oriented toward preservation of their institutional well-being, they simply won't survive. Do you agree with this statement and is it an accurate forecast of the future?

Answer: I agree wholeheartedly with the statement. I think that market research might be one answer, but it certainly won't be the cure-all. Group practices have to evolve and they are beginning to in Wisconsin more and more through the development of satellite clinics and consolidating smaller practices into groups. Before the land is purchased and the shovel goes into the ground you see transportation, living patterns, and sewerage lines being studied to determine where new housing will be going in. You see the study of population and birth trends in this country to see whether an OB-GYN person should be in a primary care satellite clinic in some of the outer areas. I think that the way that a group practice can stay at its current level or increase its practice is by doing more market research that will provide the services that the buying public wants and needs.

Question: We've talked about marketing services and marketing research. One of the methods of marketing research is the marketing audit. What are the steps in a marketing audit? How does a physician or group go about trying to find someone to conduct one for them?

Answer: The marketing audit is the first step in the marketing process. The word audit comes from the Latin word audio which means "I hear" and one of the things that we have to do is listen to the various markets or various people out there—listen to their wants and needs. The first question you might ask in a marketing audit is who are our patients or who are our potential

ALAN GAUDYNSKI: Just as marketing is new to the medical profession, medical marketing is new to the marketing profession.

patients? This constitutes a demographic study; *ie,* age, sex, religious preferences, etc. The second question is where are they located and how far are they willing to travel to my medical practice. In some of the cases we've done, it's just simply a matter of studying zip codes. Where are they coming from now? If you see some trends, go and ask those people why they're traveling 30 miles to primary care practice. A simple market questionnaire could be developed for all new patients.

Another question you might want to ask is, "What do they think they know about this organization?" We find in market research that they have misconceptions about a group practice or they don't know that a physician and his/her group may offer certain services like nutrition counseling, health education counseling, physical therapy or whatever it might be. That's where the information package comes in. More information has to be provided to those people to let them know more about your organization.

The next question you ask is what are their needs? Here quite often is where the medical profession falls short. A marketing orientation always has the patient as the primary concern, not the physician or the organization. A sales oriented organization has the doctors and their staff as the primary concern, and what's convenient for them. In the marketing process you have to ask what the patient needs. Perhaps it's evening, Saturday, and weekend office hours. You can alter your practice to include this.

The other question you might want to ask in the marketing audit is how can they be better informed about what you can do for them. That's simply providing information and you can easily do that through a patient information booklet or something like that. Tell them what your hours are, how many physicians on the staff are board certified, if you're in solo practice, what kind of a backup system do you have? Is there another doctor or are there several doctors in the area? Which emergency room to go to, etc.

There are some other things that you have to evaluate, and one of them in a marketing audit would be the external environment. That is, how many people in your area are presently seeking medical help from other people other than physicians. How many people are going to therapists and to counselors? How many people are going to chiropractors, optometrists, etc, and not going to orthopedic surgeons or ophthalmologists and why? I think you'll find especially with optometrists and chiropractors that they do much more with tracking and recall systems than do orthopedic surgeons or ophthalmologists. Very little is done in that area by physicians.

There is much more of a human relations aspect among some of these other professions that dispense what people think is medical service. The marketing audit will help a medical organization identify the needs that they can fulfill according to their resources of people, money, space, location, etc.

The four Ps again. A marketing audit can help understand the needs of past, present, and potential users of that organization. It can help provide the organization with a plan to fit the patient's needs, so that market research can actually come up with a plan that a physician and the people in his/her office can use to fit their needs.

The cost of a marketing audit in Wisconsin depends on the size of the organization and the size of the audit. It would range from $3,000 to $15,000. You get the whole Chevrolet to Cadillac range of services in between. Usually a good marketing consultant firm would indicate what would be best for that organization.

Question: There aren't many marketing and public relations firms right now doing marketing research in Wisconsin, are there?

Answer: No, there aren't and that's one of the unfortunate problems. There aren't as many because just as marketing is new to the medical profession, medical marketing is new to the marketing profession. Not many people have that expertise. It is developing, however, and there are firms that are beginning to provide these services and really do a good job at it. Some are more refined than others in dealing with the peculiarities of the profession.

Question: Many of these ideas, marketing audits, sound logical for clinics or large group practices but what advice do you have for the solo practitioner or small group who wants to apply marketing concepts to his or her practice?

Answer: Again the cost of a marketing audit varies depending on each physician's needs. Physicians and their business staff can attend medical marketing programs that are put on quite frequently through organizations in the Midwest. Most marketing firms would be willing to talk to any solo practitioner about what could possibly be done. The first visit is free. So, that if doctors feel the need, there are organizations in the state that they can go talk to, and there are seminars they can attend such as visual screening and closed circuit radio broadcasts provided by the University of Wisconsin-Extension on the subject of medical marketing. After consulting with a professional marketer physicians and staff can implement many of the recommended changes. Many cannot neglect marketing if they plan to survive in a competitive marketplace.

Question: Opponents of marketing would charge that advertising and other marketing schools will promote over-utilization of health facilities and will increase the cost of care if hospitals, clinics, and physicians pass their advertising and other promotional costs on to patients. Isn't this a real possibility?

Answer: If all physicians practiced marketing, patients would have many more opportunities to practice preventive medicine. I think if everybody would examine their own family medical usage and look into it a little bit better, I'm sure each could come up with a case where someone who had a mild medical problem and let it go because of a lack of knowledge of where to go to get it handled. This medical problem then becomes more chronic. In the long run, it was much more costly to the patient, adding to the cost of healthcare.

Good information can provide a forum for individuals to make a decision to take care of a medical problem in its early stages rather than let it reach a chronic stage that might even disable a person as the years go on. Information can help lower the cost of healthcare over a period of years for that person and maybe stop some chronic disease in its early stages. Marketing and marketing information can actually help lower the cost of healthcare.

Question: Won't that lead to duplication of services and competition among institutions and hospitals in the community?

Answer: I think it probably does. But I think also that competition is good. I think the good aspect of competition is that it increases the quality of the care provided and competition increases as the economy gets tighter and tighter; the costs of these services are going to either remain the same, or in many cases, decrease in cost. The strong, patient-oriented, cost-effective services will survive. The weak ones will not.

Question: But aren't we asking patients in the end to treat medicine like a business? And can we do this without quantifying medicine?

Answer: I think medicine has to be treated more like a business, like other professions such as accounting and law firms and other kinds of professional services. I think that it has to be treated more like a business and there are certain things that marketing can do and marketing can't do and one of them is to quantify the differences between one legal, accounting or medical problem and another. They're very difficult to do without a proper fact base. But market research can help improve the quality of those services by finding out through analyses of past users of the organization, what they liked or didn't like about the service.

In conclusion, using marketing successfully is much more complicated than that but it's really making your medical practice more patient-oriented. It's also defining what kind of business you're in. And many doctors, probably 95%, will say that they're in the healthcare business or that they're providing healthcare. And they're really not. Many are treating sickness. I think that's where there's a basic difference between consumers and doctors. They're providing healthcare information usually only after an illness or some medical problem surfaces. I think more and more consumers today are looking for ways that they can stay healthy. Through market research, marketing audits, and marketing processes they could help change the orientation of the medical practice from the curing of sickness and the treatment of illness and disease and emphasize why a person should stay healthy for all the economic, psychological, and physical reasons. Doctors really have to examine what kind of business they're in, what kind of business they want to be in, and what kind of business the consumers want them to be in.■

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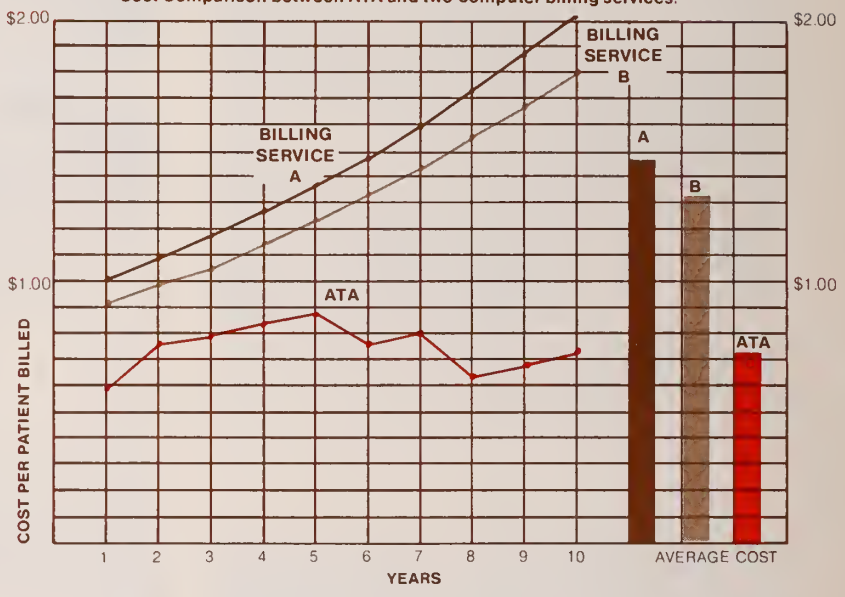

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sion and/or ataxia increases with larger doses in the elderly, it is recommended that the dosage be limited to 15 mg.

Moreover, the efficacy and safety of Dalmane for the treatment of insomnia have been demonstrated in thousands of patients with a variety of primary medical conditions, including cardiovascular, neuropsychiatric, endocrine-metabolic, gastrointestinal, genitourinary, respiratory and musculoskeletal disorders.[1] Dalmane (flurazepam HCl/Roche) is contraindicated in pregnancy and in patients hypersensitive to the drug.

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Rebound insomnia—a worsening of sleep beyond pretherapy levels after drug discontinuation—has been reported as a potential clinical problem with some hypnotics.[9,10] However, this problem has not been reported with Dalmane. In eight out of eight sleep laboratory studies, there were no reports of rebound insomnia.[11] When you prescribe Dalmane, you can be confident of efficacy that enhances therapeutic progress. Your insomniac patients can be assured of a restful night, night after night—a good start for a good morning.

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Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

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Surgeon with Thoracic general vascular training, Ophthalmologist, and ENT, to join a progressive multispecialty group of 17 physicians consisting of General/Family Medicine, General Surgery, Internal Medicine, OB-GYN, Ophthalmology, Orthopaedic Surgeon, Pediatrics/Adolescent Medicine, and Radiology. Subspecialties include: Pathology, Vascular Surgery, Cardiovascular Diseases, Gastroenterology and Endoscopy. We are located in a fast growing, scenic, lake country area between Milwaukee and Madison and can offer excellent hospital, schools, and recreational facilities. Full fringe benefit package. Contact: James F Dowd, Admin, Wilkinson Clinic SC, 915 East Summit Ave, Oconomowoc, Wis 53066; ph 414/567-4433. 9tfn/81

Physicians Exchange

continued

Doctors needed—in Wisconsin. All specialties and all locations. For confidential information, mail your CV to: Medicus, 1525 Wisconsin Ave, Grafton, WI 53024. 6tfn/82

Wausau Medical Center, SC, a 50-physician multispecialty group has openings for physicians in the following specialties: *Neurology, Otolaryngology, Cardiology* and *General Surgery* with a fellowship training in *Peripheral Vascular Surgery*. Competitive first-year salary, incentive plan thereafter. Comprehensive fringe benefits. New facility near new hospital. Located in beautiful, quiet, central Wisconsin, metropolitan area of 65,000. Recreational opportunities abundant. For more information contact: K L Day, MD, Wausau Medical Center, SC, 2727 Plaza Drive, Wausau, Wis 54401, or call collect 715/847-3351. 6tfn/82

Full Time or Semi-Retired Family Physician needed to work three to five days per week in a small rural clinic. No emergency or hospital work required. Excellent setting with bountiful hunting and fishing opportunities. Located in the heart of Northwest Wisconsin's scenic vacation land. For more information contact Dr Thomas Fenger, Chief Executive Officer, Indianhead Medical Group, 1020 Lakeshore Dr, Rice Lake, Wis 54868; ph 715/234-9031 or 715/354-7939. 7/82

General Surgeon. Enjoy the security of group practice with the freedom of independent practice. If you are a Board certified or Board eligible general surgeon, we have an interesting opportunity for you. A general surgeon is needed immediately to form an independent practice in a very desirable Northern Wisconsin community with a drawing population of 100,000. All major specialists available for consultation. A growing community hospital with 240-beds with excellent medical and surgical subspecialty representation. Opportunities for endoscopy and peripheral vascular surgery also exist. For further information write: Administrator, PO Box 1646, Wausau, Wis 54401. 7-9/82

Family Practice Physician to share fully equipped medical office in central Wisconsin city. Opportunity for partnership and eventual purchase of practice. Excellent recreational, educational, hospital, and civic advantages. Send curriculum vitae to Dept 503 in care of the Journal. 6tfn/82

Family Practitioner. Immediate need to associate with busy, Board certified family practitioner in Tomah. Modern local clinic and hospital and formal association with 52-physician multispecialty clinic in La Crosse. Tomah is an active, growing community of 7,000 with a medical service area of 20,000. Contact: P S Shultz, MD, Medical Director, Skemp-Grandview-La Crosse Clinic, 815 S 10th St, La Crosse, WI 54601; ph 608/782-9760. 5-7/82

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Board eligible/Certified FP's needed at multiple locations in Northeastern rural Wisconsin. Financial assistance available and negotiable. Excellent locations, communities, recreation areas. Contact J Schumacher, Administrator, Calumet Memorial Hospital, Chilton, Wis 53014; ph 414/849-2386. 7-9/82

Family Practice, Sparta Clinic, Ltd, Sparta, Wis, a six physician group offers an excellent opportunity for a family physician willing to do some obstetrics. The Clinic is located one block from St Mary's Hospital and 25 miles from a major referral center. Salary guarantee available plus potential for bonus based on work done. Clinic pays all insurance and pension and profit sharing after one year. MD or DO. Contact Thomas E Flood, Administrator, Sparta Clinic, Ltd, PO Box 250, Sparta, Wis 54656; ph 608/269-6731. 7-9/82

Faculty Member Family Practice Program. The Black Hawk Area Medical Education Foundation is recruiting a Board Certified Family Physician to join its Family Practice Residency Program in Waterloo, Iowa. The program is community-based, affiliated with the University of Iowa College of Medicine, and part of the Iowa Network of Family Practice Residency Programs. The Waterloo metropolitan area has 125,000 people, four hospitals, and is well represented in the medical specialties. Applicants should have a MD degree, be eligible for licensure in Iowa, and should have several years of practice experience. Major duties include teaching residents in all aspects of patient care, including obstetrics, and also providing patient care. Other duties include some program administration and assisting in research from time to time. A salary in the range of $60,000 per year with an additional 20% fringe benefit package is offered. Other fringe benefits relating to retirement, moving expenses, and continuing education are provided. Please submit your resume to: Charles A Waterbury, MD, Program Director, Black Hawk Area Medical Education Foundation, 441 East San Marnan Dr, Waterloo, Iowa 50702; ph (319) 234-4419. Equal Opportunity Employer. 5-7/82

Family Practitioners and Internists. 40-bed hospital on the shores of Lake Superior in the Upper Peninsula of Michigan seeks additional staff in family practice and internal medicine. Year-round recreational area with opportunity for challenging medical practice. Office building, staff, and equipment negotiable. Contact William Hermann, Executive Vice President, Munising Memorial Hospital, Route 1, Box 501, Munising, Michigan 49862. p5-7/82

Internist wanted. Board certified or eligible with/without subspecialty, to practice in conjunction with a 6-member Internal Medicine Department in a 22-member multispecialty group. Present subspecialties: Gastroenterology and cardiology. The group is in Southeastern Wisconsin, in a city of 100,000 between two major metropolitan areas of greater than one million. If interested, please send CV to: Stephen L Wagner, Kurten Medical Group, 2405 Northwestern Ave, Racine, Wis 53404. All inquiries will be kept confidential. 3tfn/82

The Racine Medical Clinic, a progressive cluster corporation of 25 physicians, is currently seeking an orthopedic surgeon and an invasive cardiologist. Full benefits, unlimited earnings and a full and exciting practice are offered. Please contact: Roger D Lacock, Administrator, Racine Medical Clinic, 5625 Washington Ave, Racine, WI 53406; ph 414/886-5000. 1tfn/82

Dermatologist, Family Practitioner needed to join multispecialty group of 33 physicians dedicated to primary care in East Central Wisconsin community. City population 48,000, drawing area 100,000. Attractive income arrangements, association membership possible after one year, pension and profit sharing, extensive fringe benefits. Contact R B Windsor, MD, 1011 North 8th St, Sheboygan, Wis 53081; ph 414/457-4461. 5tfn/82

Pediatric, Family Practice positions available in 13-member multispecialty group. Inquire: General Clinic of West Bend, Inc, 279 S 17th Ave, West Bend, Wis 53095. 2tfn/82

Medical Placement Associates is recruiting in this area on behalf of clients throughout the country. Opportunities exist in *Anesthesiology, Gastroenterology, Gynecology, Internal Medicine, Obstetrics, Ophthalmology, Orthopaedics, Otolaryngology, Pediatrics, Radiology.* For further particulars call Steve Sell (collect) at (313) 557-3350, or write: Medical Placement Associates, 18877 West Ten Mile Road, Southfield, MI 48075. p6/82

Family Physician or Internist to join three-man family and general practice group in the heart of North Central Wisconsin vacationland. First year guaranteed salary. Numerous fringe benefits. Clinic across from hospital. Send CV to: O M Francisco, MD, 221 E Washington Ave, Tomahawk, Wis 54487; ph 715/453-2147. 5tfn/82

Wanted. Board certified or eligible orthopedic surgeon to practice in conjunction with a 5-member surgery department in a 22-member multispecialty group. Present surgical specialties: thoracic and vascular surgery, general surgery and urology. The group is located in the upper midwest, in a city of 100,000 between two major metropolitan areas of greater than one million. If interested, please send CV to: Stephen Wagner, Kurten Medical Group, SC, 2405 Northwestern Ave, Racine, Wis 53404. All inquiries will be kept confidential. 12tfn/80

Allied Health

Solicitation of Proposals. Eau Claire County is soliciting proposals for a Medical Services Coordinator. Specifications are available from the Administrator Coordinator's Office, 721 Oxford, Eau Claire, Wis 54701. All written proposals must be submitted to the Administrator Coordinator's Office by noon on Aug 2, 1982. For further information contact the administrator's office at 721 Oxford or 715/839-5106. 7/82

Medical Facilities

Immediate solo practice available in Jefferson, Wisconsin, due to the recent death of Richard H Siedenburg, MD. Expandable building with three large lots available. Lease or purchase. Contact Miller Law Office, PO Box 417, Jefferson, Wisconsin 53549; ph 414/674-3345. g11tfn/81

Milwaukee. Busy family medical center for sale. Will introduce. Good for teaching interns and residents in Family Practice. Contact: R Gonzalez, MD; ph 414/344-1120 or 414/476-8624. 3-8/82

Wanted: X-Ray Equipment. Ultrasonic and Diathermy Units in workable condition. Reasonable. Info: Call 414/444-7525. 5-7/82

Office spaces for rent. New professional building in Menomonie, Wis, city of 14,000, 70 minutes from Minneapolis/St Paul on Interstate 94. Building has dental offices. Excellent opportunity for private practice. Contact Ryder Realty, 815 6th Ave, Menomonie, Wis 54751; ph 715/235-8800. 5-7/82

For Sale: Portable Burdick EKG with cart. Bio-refrigerator; sterilizer; portable electric typewriter; centrifuges (2); stainless disposal cans; 3-M dry photocopier; infant scale; small instruments; incidental lab equipment. Contact 1/414-769-9697 evenings. All excellent condition. Should be seen. 6/82*

Medical office space for lease. New Swiss chalet style building in fast growing community. Needs family practitioner, pediatrician, etc. Building has dentist and pharmacy. Very reasonably priced in Waukesha County near expressway. Info: call 414/781-1155. 7tfn/82

For Sale: American Electromedics Model AE 85AR Tympanometer, 10 rolls Normal paper and Rock Eartip kit. Excellent condition. Contact Drs Sandin and Vernier, SC, 2101 Beaser Ave, Ashland, Wis 54806; ph 715/682-5277. p7/82

Miscellaneous

Physicians Signature Loans to $50,000. Up to 7 years to repay. No prepayment penalties. Prompt, courteous service. Physicians Service Assn, Atlanta, GA. Toll-Free (800) 241/6905. 4tfn/82*

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Executive Country Estate. English Tudor stucco 1½ story 4-bedroom, custom built 1977 on 7½ acres near Rice Lake, Wis on trout river. 2½ ceramic baths, Andersen windows, oak trim, plastered, custom oak cabinets, elegantly carpeted and draped. Formal dining room, Mankato stone fireplace in living room. Bricked walkout basement with fieldstone fireplace in recreation room, 2 paneled offices, wood and oil heating systems. Cathedral open staircase, open beam breezeway, balcony, double garage, beautifully landscaped, oaks, and pines. Over $100,000. Terms. By owner Ed Ruhr, Rt 1, Rice Lake, Wis; ph 715/234-9410. p7/82

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OCTOBER 31-NOVEMBER 6, 1982 (India): *First US-India Radiology Conference,* sponsored by the Medical College of Wisconsin (MCW), Milwaukee, Wisconsin, and the Indian Radiological Association, New Delhi. It is recognized by the Atomic Energy Commission of India, Bombay. Program director: Jagmeet S Soin, MD, associate professor of radiology and medicine at MCW. This CME course meets the criteria for 30 credit hours in Category I of the Physician's Recognition Award of the AMA and 30 credit hours of Liaison Committee on Continuing Medical Education Category I CME credits. Info: Jagmeet S Soin, MD, MCW, 8700 West Wisconsin Ave, Milwaukee, Wis 53226, or call toll-free 1-800-558-4355. In Wisconsin call 414/784-8430.

AMA

DECEMBER 5-8, 1982: Interim AMA House of Delegates, Miami Beach, Fl.

JUNE 19-23, 1983: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 4-7, 1983: Interim AMA House of Delegates, Los Angeles, CA. ■

Tenth Annual Illinois Congress on Continuing Medical Education

September 24-25, 1982

Friday, Sept 24, 1:00pm to Saturday, Sept 25, 5:00pm

Drake Oakbrook Hotel, West 22nd St at York Road

Oak Brook, Illinois

Determining What Physicians Need to Learn: Needs Identification in CME

This year's Congress sponsored by the Illinois Council on Continuing Medical Education is the third of a four-year program cycle presenting all the fundamentals of CME planning. The 1982 program focuses on effective needs identification procedures as they apply to CME program planning. In response to demand, this year's Congress has been lengthened to two full days—Friday afternoon and evening, all day Saturday—to offer a wider choice of workshops and free time for informal discussion.

Highlighting this year's program will be ***Edmund D Pellegrino, MD,*** John Carroll University Professor of Medicine and Medical Humanities, Georgetown University Medical Center, Washington, DC.

Most of the Congress consists of 25 small-group workshops, such as: Avoiding Pitfalls in the Use of Interest Surveys and Audience Feedback, Malpractice Data in Needs Identification, Defining Audiences in Needs Identification, Overview of Needs Identification Methods, and Matching Needs to CME Goals and Evaluation Strategies. Other workshops which will be included are: Computer-Assisted Instruction and Applications of Mini-Computers to CME, Administrative Strategies in CME Planning, Developing Goals and Objectives, and The Non-Physician CME Planner: Can Educators Aid CME Planning.

For additional information, write or call the **Illinois Council/CME, 55 E Monroe, Suite 3510, Chicago, Illinois 60603 (ph 312/236-6110).**

AMA 1982 CME/Sports Getaway

The American Medical Association's 1982 CME/Golf Digest-Tennis Program will be held October 10-16 at the Doral Country Club and Hotel, Miami, Florida.

Five days of sports instruction and tournament play, AMA Video Clinics on alcoholism and hypertension, and a four-hour seminar on retirement planning are highlights of the week-long getaway. The Video Clinic courses offer a total of 8 Category 1 credit hours.

Golf pro Bob Toski, his Golf Digest staff, and tennis greats Arthur Ashe and Pacho Castillo will lead instruction programs for physicians and their sports-minded spouses. Capping a full schedule of individual lessons, golf and tennis clinics, and championship tournaments will be a final-night awards dinner.

The AMA Video Clinic on alcoholism discusses the diagnosis, pathophysiology and treatment of alcoholism, with particular emphasis on long-term management. Medical consultant is Alan Brovar, MD, Career Teacher for the National Institute on Alcohol Abuse and Alcoholism, and Assistant Professor of Psychiatry at the University of California School of Medicine, Los Angeles.

Donald G Vidt, MD, Head of the Clinical Section of the Department of Hypertension and Nephrology at the Cleveland Clinic Foundation, Cleveland, Ohio, is the course director for the AMA Video Clinic on hypertension. This program focuses on hypertension risk factors, clinical evaluation of the hypertensive patient, and the use of available antihypertensive agents.

Both Video Clinics will be supplemented by faculty who will lead discussion and field questions.

Karen Zupko, Director of the AMA Department of Practice Management, will be joined by insurance consultant Deane H Tank, CLU, in a four-hour course designed to help physicians and spouses prepare for eventual retirement or possible career change. The discussion will cover personal and psychological planning, handling practice closings, intermediate practice transitions, and insurance and financial considerations.

Costs of the golf program are $1199 for physicians, $799 for golfing spouses, and $575 for non-golfing spouses. Costs of the tennis program are $995 for physicians, $650 for playing spouses, and $575 for non-playing spouses. Non-players will enjoy swimming, shuffleboard, sightseeing, and many other activities offered at the spectacular 2,400-acre Doral resort.

Deadline for reservations is September 1. Contact Elaine M Tejcek at AMA: 312/751-6057 for details. ■

Publication Information

MANUSCRIPTS. Manuscripts will be accepted for consideration with the understanding that they are original, have never before been published, and are contributed solely to the WISCONSIN MEDICAL JOURNAL. The Editorial Board reserves the right to limit manuscripts to two printed pages, with additional pages to be subsidized by the author(s) on the basis of $100 per page. A maximum of four illustrations and/or tables may be included; additional ones will be charged to author(s) at cost. Address manuscripts to Medical Editor, Wisconsin Medical Journal, Box 1109, Madison, Wis 53701.

Rejected manuscripts are returned by regular mail. Accepted manuscripts become the property of the JOURNAL and are not returned. Submit one original and two carbon copies. Author should retain one carbon copy. Format and style should follow that of the *AMA Style Book and Editorial Manual.* Manuscripts are subject to editorial modification and such revisions as bring them into conformity with JOURNAL style.

Contributors will be sent a copy of their article after it has been edited and set in type for final approval before publication. A form for ordering reprints will accompany the article.

Under ordinary circumstances manuscripts are published about six months following acceptance, and in the order in which they are received.

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Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the JOURNAL. In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society.

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LET THESE GUIDES HELP YOU

THE FOLLOWING GUIDES and manuals have been prepared or obtained at the direction of the Board of Directors and/or commissions and committees of the State Medical Society of Wisconsin to be of direct personal assistance to the physician or his county medical society. Each is available (some without cost, others at nominal cost) upon request to the Communications Dept., State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

- **Interprofessional Code (1977 Revision)**—An instrument for better understanding between attorneys and physicians with reference to medical testimony and interprofessional conduct and practices.
- **Communications Guide for Wisconsin Hospitals and Physicians**—Establishes a communications guide for Wisconsin hospitals and physicians to promote cooperation between the allied medical professions and those who report medical news.
- **Comments on Fee Splitting Statute, Including Chapter 82, Laws of Wisconsin, 1973**—Governing physicians and others and authorizing employment of physicians by hospitals and others.
- **Approved Program in Continuing Medical Education**—Explains the State Medical Society of Wisconsin's accreditation program for continuing medical education in conjunction with the American Medical Association's Council on Medical Education.
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- **Legal Responsibilities of the Physician-Patient Relationship**
- **Report of the Chiropractic Study Committee to the Governor's Health Planning and Policy Task Force**—Recommendations in this report were adopted by the Governor's Health Planning and Policy Task Force, October 23, 1972.
- **A Scientific Test of the Chiropractic Theory**—The first experimental study of the basis of the theory demonstrates that it is erroneous. Written by Edmund S. Crelin and reprinted by permission of *American Scientist.*
- **Some Straight 'Dope' on Marijuana**—Increasing evidence appearing regularly that marijuana is hazardous to health has led the State Medical Society of Wisconsin to declare it to be a dangerous drug. This brochure explains what marijuana is, who uses it, and points out some of the psychological and physiological hazards associated with its use.
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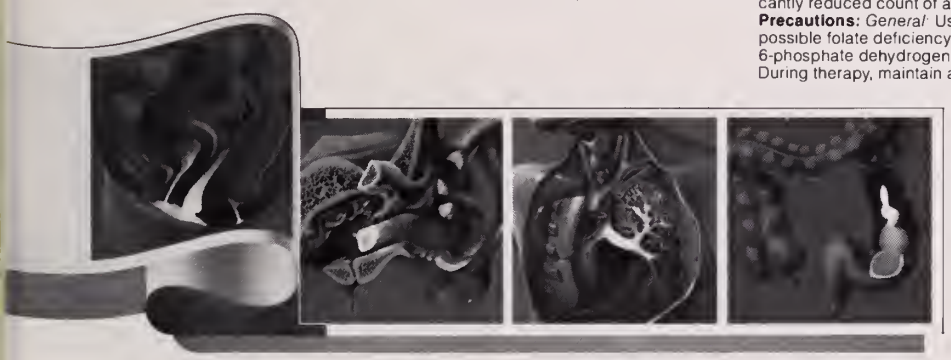

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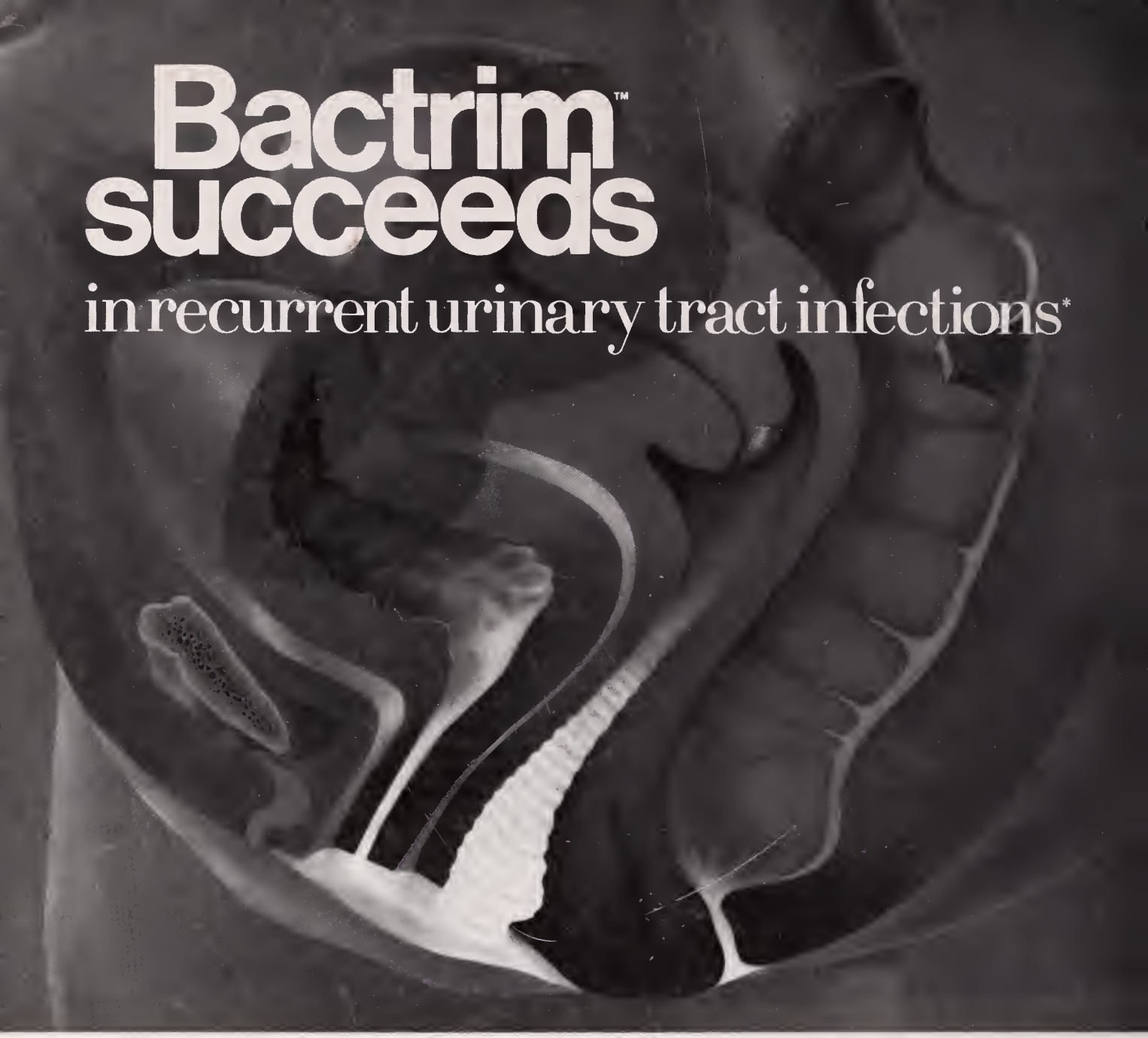

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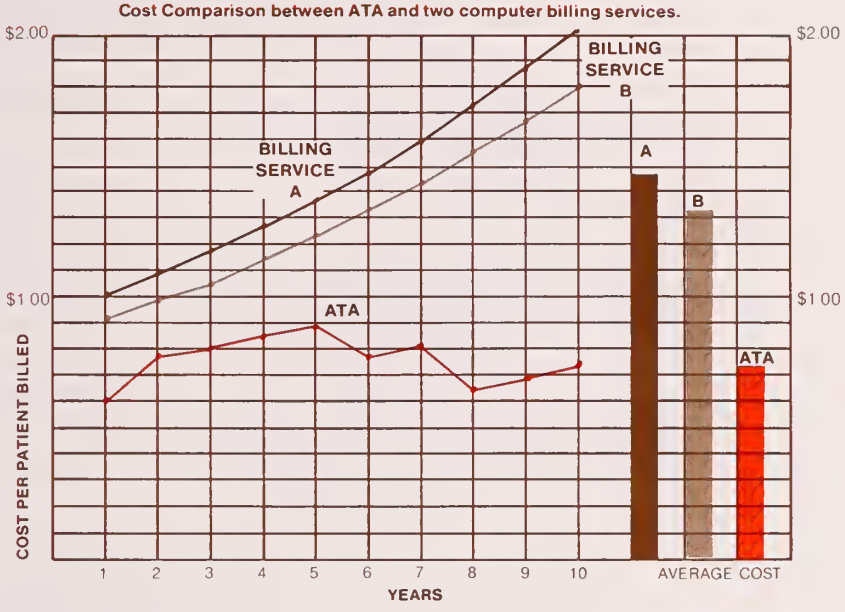

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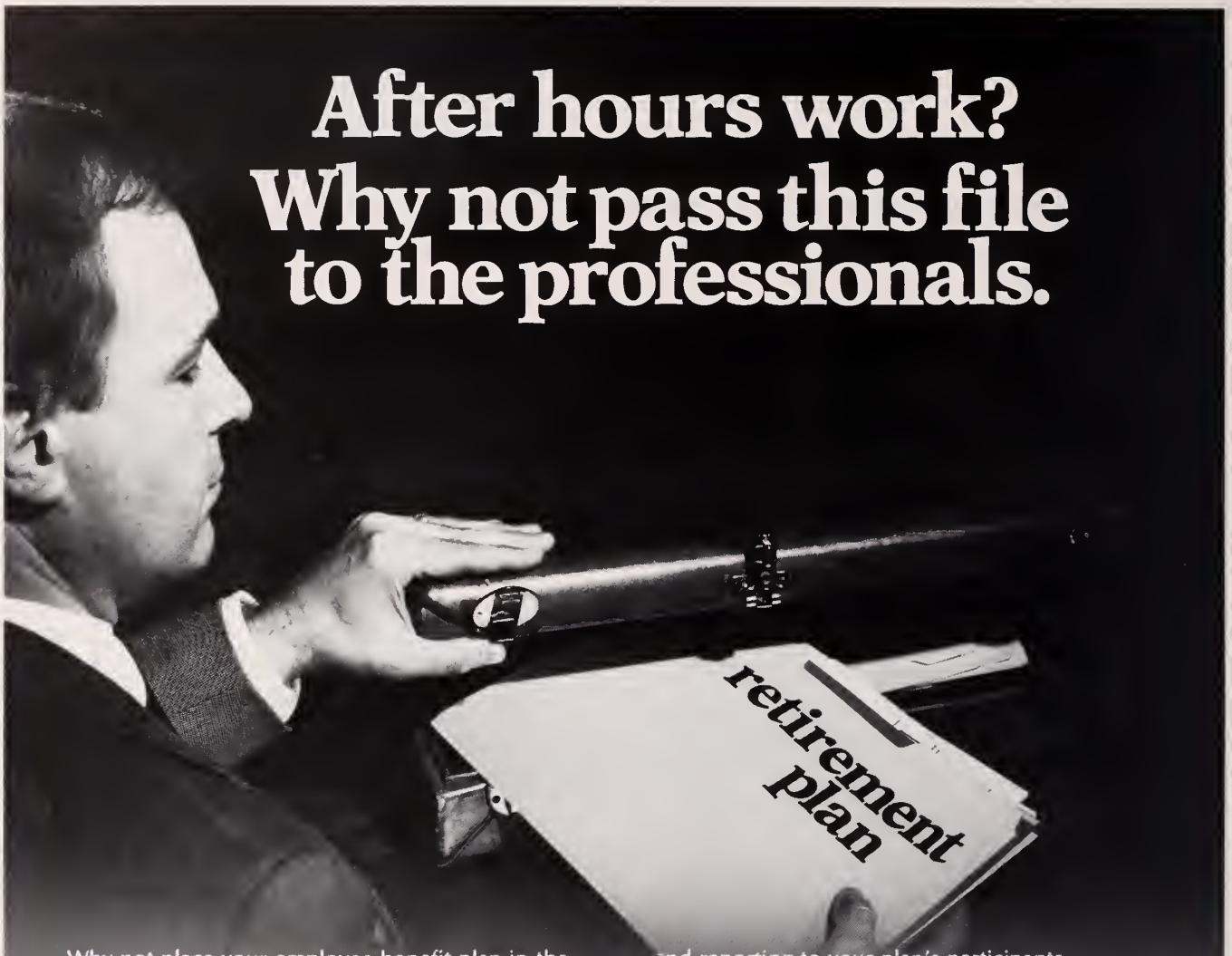

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.....Gerald C Kempthorne, MD

The Society as a power of influence

EVERY PRESIDENT needs to reflect on the kind of image he wants to cast. Each president has an obligation to try to assemble an overview of the scope of the State Medical Society in its role within the whole spectrum of our statewide social structure. It has been said that the only selection process more meticulous than the one utilized in the development of a physician is the procedure employed to select astronauts. Consequently, it is my observation that people, in general, look to the "house of medicine" for direction in the delivery of health care. The people of Wisconsin envision us as the body of doctors responsible for medical care for them and their families. They see no other body, structured as we are, to carry out their health care goals and needs. Therefore, it is timely for all of us to nurture and assist this perception. It may well be the time to stand back and look at our profession from a philosophic perspective.

At our leadership conference last year, I stated: "It was crucial for all of us to recognize the current political world for what it really was. Because of the current conservative image we were being lulled into a sleep of a no crisis mentality with a no action response. Some of us believed that the Reagan/Dreyfus era immunized us from outside intervention in our sanctuary of complacency. Many believed because of less regulation, less bureaucracy, less taxes and less government intervention that we need not face the 'forces of change.' This was not the time for physician apathy in the world we currently find ourselves. Did we really feel that the conservative milieu of the moment guaranteed us a barrier to intrusion into our *status quo* image?"

Certainly, this is the "golden opportunity" we have all looked for since organized medicine has become a force in our society. The federal government is tossing us the greatest challenge we have ever been given. Direction from Washington is clearly being downgraded for local units to pickup the initiative along with the national organized medicine model, the AMA. A scramble could result for health care delivery and policy making direction. In the past organized medicine has not demonstrated unified and clear direction, because we were so busy responding to the courts, government, and third-party payers. The parties, least knowledgeable, have been determining what is best for the patients we serve. We know how to treat patients scientifically and compassionately, but we need to develop a "statesmanship of medicine" comprised of strong leadership integrated with positive, constructive, and innovative means of delivering quality care. Some segments of our society no longer see us as an influential force in health care delivery. They can't imagine we are capable of "shaking off the old boys' club image" in favor of positive direction for the future. Nothing could be further from the truth. However, it remains problematical whether we can choose to opt for a socially stronger position as an influential force in Wisconsin.

The State Medical Society is a dynamic influence, but it has the potential of being even more influential. It is my firm conviction that the 5,200 members of the grand and noble profession of medicine united as a group should speak for all matters pertaining to the delivery of health care. No other organization, structured as we are, has the same power of influence as we do. Therefore, statements on fees, availability of care, peer review, costs, research, medically poor, delivery systems, and related programs *should* emanate from us in the form of constructive, imaginative, and innovative concepts. The diversity of our State Medical Society should be helpful in this cause, since we truly represent the entire physician population community in Wisconsin.

Traditions are great acts to follow. Is it time to create some new ones? ■

Editorials WAYNE J BOULANGER, MD, *Editorial Director*

Official positions of the Society will be expressly identified as such; all others are views of the writer and not necessarily those of the Society.

Hail to thee, our alma mater

THE UNIVERSITY OF Wisconsin is a world -renowned academic institution. Its high standards are widely acknowledged, and the achievements of its faculty and alumni have given Wisconsin citizens strong ammunition for rebuttal when dealing with those who would criticize the sometimes libertine attitudes emanating from our great seat of learning.

Suddenly though, our university has become an embarrassment even to its most avid supporters.

What can we say to our critics now when they remind us of those abortions induced recently in midtrimester pregnancies in our University Obstetrics Department—abortions which produced babies capable of struggling for life outside the uterus?

And what can we say when those critics snicker about our obstetricians' ambivalent behavior in scurrying to transfer the aborted babies to a neonatal intensive care unit, which although it is the last word in medical gadgetry, isn't as perfect an environment as the one from which the babies were wrested in the first place?

We really can't say anything that makes any sense. We can't explain that sort of activity in rational terms, because it is not rational. Since the purpose of an abortion is to interrupt a pregnancy at a point which does not permit the baby's survival, wouldn't it be more consistent just to stand there and do nothing while the baby whose death you initiated gasps its last? Rushing it to an intensive care unit isn't going to do anything but add to the expense and prolong the agony.

Mistakes are a part of medicine; they can be expected to occur sporadically. When they occur twice in the space of a few days, however, brisk corrective action must be taken. It is probably too much to expect that rules regarding eligibility for abortion will be tightened in this "enlightened" state of ours. It is not too much to expect steps to be taken to prevent another similar fiasco.

Science at UW has come a long way. It has taken a giant step backward.—WJB

Digital subtraction angiography

ANTICIPATING A proliferation of digital subtraction angiography suites comparable to that seen with the development of the CT scanner, the State Division of Health assembled a study group to advise it on alternatives to pursue with regard to regulation of the service. The study group was asked to assist in the formulation of guidelines which would address these questions:

1) Should digital subtraction angiography be considered a new service with regard to Certificate-of-Need?

2) Since it appears that according to existing law (based on cost of instituting the service) a Certificate-of-Need will be required, should review by the State Department of Health and Social Services be substantive or nonsubstantive?

3) In the event that an institution without angiographic services submits an application, what conditions must be met to gain approval?

4) Will Certificates-of-Need be granted to individuals and clinics?

The study group has recommended to the Division of Health the following guidelines:

1) That Digital Subtraction Angiography be considered an extension of current angiographic services and not a new service.

2) That reviews of applications from hospitals currently having angiographic services be nonsubstantive. This appears to be impossible because of current regulations.

3) That quality control committees of hospitals be alerted to the potential of poor patient selection for the examination.

4) That Digital Subtraction Arteriography be restricted to hospitals and clinics in hospital settings on grounds that these are the providers with the necessary medical support and peer review.

5) That hospitals without angiography would have to meet the following criteria to obtain Digital Subtraction Arteriography: a) should have recognized department of radiology; 2) should only be added if angiographic capabilities were added; and 3) there should be a vascular surgeon on the staff and a radiologist who is recognized by either specific training or experience as a vascular radiologist.

Whether the Division accepts the group's recommendations remains to be seen. Acceptance by the Division could prevent a lot of confusion and red tape. It might even save more money.—WJB

Roosevelt/Reagan—Schrank/Hinckley

IT HAPPENED IN Milwaukee in October 1912. Former President Theodore Roosevelt was campaigning for reelection. A 36-year-old bartender from New York had pursued Roosevelt through eight states, awaiting his chance to assassinate the former president. That day John Schrank came within six feet of his victim and fired a single shot from his .38 caliber revolver. The pistol was quickly knocked from Schrank's hand preventing further shooting. The bullet struck Roosevelt in the right side of his chest. Fortunately, the bullet passed first through a metal spectacle case and then through a folded 50-page manuscript before entering the victim's pectoralis major muscle and travelling upward five inches.

Mr Roosevelt proceeded to give an 80-minute speech in a very dramatic manner. Four distinguished Chicago surgeons were requested to come to Milwaukee by special train for consultation. However, there was a change of plans, and the candidate instead went to Chicago very early the following morning. There he was met by Dr John B Murphy who took him to Mercy Hospital where it was decided to treat his wound conservatively. The bullet remained embedded in his chest wall the rest of his life.

Back in Milwaukee, Schrank was arraigned in court on the day after the shooting and he immediately pleaded guilty to the charge of assault with intent to kill and murder. The judge bound him over for trial, and later allowed alienists, as psychiatrists were then known, to examine him. The trial was postponed until after the presidential election. The court then appointed a "lunacy committee" to examine Schrank, and the members unanimously recommended that Schrank be sent to an asylum.

Newspaper reports from 1912 complimented the presiding judge for the course he took in submitting the question of Schrank's sanity to a court-appointed body of alienists instead of leaving the question to a jury who would be at the tender mercy of alienists appointed and liked by both state and defense. The judge instructed the examining physicians that he was using this procedure instead of a jury trial, because, as a rule, in trials by jury the case tends to resolve itself into a battle of medical experts, and in his experience, he had never witnessed a case where the testimony of the experts on one side was not directly contradicted by testimony of as many or more experts on the other side. He went on to state that where men especially trained in mental and nervous diseases disagree, how can it be expected that a jury of twelve laymen should agree? He went on to say that such testimony had been very unsatisfactory to the jury and to the court, and was generally very expensive to the community. He concluded by saying that it had often been a scandal to the medical profession, a source of travesty to judicial procedure and a means of defeating the ends of justice. This was referred to in the press as the "Wisconsin idea." Newspapers all over North America recommended that this idea should be copied by every state and every province of Canada.

A noted Washington criminologist recommended that the government establish a bureau to oversee and keep under constant surveillance men of this type. He further stated that such men were potentially dangerous but no chronic criminals, and their one offense was of such a heinous nature that the desirability of their restraint was evident and that Congress would take definite action on this point before long!

Schrank himself objected to being regarded as a lunatic and stated that he was sane and knew what he was doing all the time. Six weeks after the assassination attempt Schrank was transferred by train to the Northern Hospital for the Insane at Oshkosh. In 1914 the new Central State Hospital for the criminally insane at the Wisconsin State Prison in Waupun was opened. Schrank was then transferred there. He was in prison for 31 years and finally died in 1943 at the age of 67. His body was sent to the Medical School at Marquette University.

Almost 70 years later John Hinckley, Jr attempted to assassinate President Reagan in Washington. The prolonged legal maneuverings and machinations as well as the sanity hearings have been exhaustingly covered by all types of media. When the trial finally came about, there was conflicting testimony presented by opposing batteries of psychiatrists. The jury was given instructions that would have to be considered confusing, and the verdict was reported to have distressed, disgusted, and dismayed the jurors and the public as well. Psychiatry in court came under extensive scrutiny and criticism.

What would the situation have been had the 1981 assassination attempt occurred in Wisconsin? The law in Wisconsin is such that the defense must show that

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the defendant is insane, whereas under federal law the prosecutor has the burden of proof to show that the defendant is sane, as in the Hinckley case. Also, rather than considering the question of insanity at the same time as whether the defendant committed an act, Wisconsin juries first determine whether the defendant committed a crime. Then they determine if the defendant was insane and if the person is still suffering from mental disease or defect and whether the person should be committed to an institution. Once a defendant is committed, it is much easier to keep the person confined because the only question that must be answered is whether the person continues to be dangerous to himself, *not* whether he or she is still insane. Consequently, the insanity defense is seldom used in Wisconsin. In Wisconsin, defendants found innocent by reason of insanity have been committed indefinitely and in many cases have been incarcerated longer in mental hospitals than they would have been if they had been found guilty of the crime that they are accused of and then sentenced to a prison term. Which system seems more logical and reasonable?
—VSF

Rabies in Wisconsin

THE VIRUS SECTION of the State Laboratory of Hygiene recently reported on rabies in the state for 1981. A total of 338 cases, this represents the largest number of laboratory confirmations in recent history, an increase of 360% above the average for the years 1975-79. Skunk rabies accounted for 70% of the 1981 cases, and 49 of Wisconsin's 53 counties had one or more confirmed cases of skunk rabies.

Despite the sharp upturn of rabies in animals, there have been no human cases of rabies reported in Wisconsin since 1959. This is a favorable commentary for the educational program carried out by the State Laboratory of Hygiene and the response by Wisconsin physicians.

Although skunks constituted 91% of the 1981 wildlife cases, there were also 5% in bats and 3% in foxes. One hundred ninety-five raccoons were also examined, but there were no positives. Thus far in 1982 there have been three positive raccoons detected. These are the first rabid raccoons in Wisconsin since 1967. In addition in 1981 there were 78 domestic rabid animals, divided among dogs, cats, horses, and other farm animals. There were only 14 rabid dogs reported, a marked drop from the year before. It is believed that this may be due to the legislation requiring all dogs four months of age and older to be immunized against rabies. Since a higher percentage of human exposure occurs with domestic animals, this emphasizes the importance of providing domestic animals, including cats and valuable farm animals, with the anti-rabies immunization.

The new human diploid cell strain rabies vaccine (HDCV) is now available from 16 hospitals and medical centers throughout the state. The same pharmacies also stock the Rabies Immune Globulin (Human). These are located at Ashland, Cumberland, Eau Claire, Green Bay, Janesville, Kenosha, La Crosse, Ladysmith, Madison, Marshfield, Milwaukee, Oshkosh, Platteville, Sheboygan, Wausau, and Woodruff.—VSF

Editor's note: The State Laboratory of Hygiene recently published a brochure on the "Diagnosis of Rabies." It has been distributed to healthcare providers, including those physicians most likely to become involved. The brochure includes information on (a) source of specimens, (b) circumstances required, (c) laboratory tests performed, (d) conditions for shipments, (e) cost of examination, (f) management, (g) rationale of treatment, and (h) rabies postexposure prophylaxis guide, March 1980. The State Laboratory has a quantity available to anyone wishing copies. Requests should be directed to: State Laboratory of Hygiene, University of Wisconsin Center for Health Sciences, 465 Henry Mall, Madison, Wis 53706; or phone (608) 262-1489.

Rights

EVERYONE HAS RIGHTS. Judging by the legal maneuverings and repeated delays in many cases, it appears that bandits, rapists, and murderers have more rights than anybody. Recently the city council of Madison granted a group the right to hold a marijuana rally. The council persons may have been partially motivated by the fact that they were about to be taken into court after having originally denied the permit for the gathering.

One of the pathetic exhibits at the rally was a pen with a few children cooped up inside a snow fence. This scientific display was to prove to the onlookers that the children were not damaged and had no chromosomal defects. Obviously, the exhibitors would not display a coop of congenital idiots. If a pen of animals was displayed under similar circumstances, it probably would result in a flurry of protests from some militant animal rights groups.

One cruel banner imitated the lettering design of the American Cancer Society, and it said, "Thank You for Pot Smoking."

At this jolly gathering the newspapers reported that one man carried a grocery bag filled with joints around the crowd offering the pot for free. Others smoked joints the size of cigars.

Apparently the scientific data which has been widely publicized about the harmful effects of marijuana has not filtered down to the American Cannabis Society. After all, they have their rights.
—VSF■

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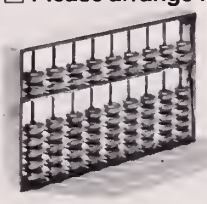

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Letters

The Editors would like to encourage physicians to contribute to the LETTERS section where they can ventilate their frustrations as well as opinions. This feature is intended to be lively and spirited as well as informative and educational. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address correspondence to: The Editor, Wisconsin Medical Journal, Box 1109, Madison, Wis 53701.

AAMA—Medicine's best ally

AS THE PRACTICE of medicine has become more complex and specialized, the medical assistant has become the physician's most valuable allied health professional—and the American Association of Medical Assistants (AAMA) has become organized medicine's best ally. The professional development offered to its members by AAMA can make the difference between an amateur and a professional office staff.

Professional medical assistants are committed to self-development and lifelong learning. They are concerned not only with earning a living but also with serving patients.

Qualified medical assistants can perform many administrative, clinical, managerial and supervisory functions, freeing the physician to spend more time in direct patient contact. AAMA is dedicated to the education of this multi-skilled professional.

AAMA recognizes that competence in the field requires medical assistants to communicate effectively, to adhere to ethical and legal standards of medical practice, respond to medical emergencies, and to demonstrate professional characteristics. In response to increased patient awareness and technological advances, medical assistants, through AAMA, have assumed more responsibility for patient care tasks and developed specialties within the field.

Medical assistants are the first and last health care professionals to see the patient in the office. They are in a unique position to reflect the philosophy of the office and set the tone for everything that happens there. The medical assistant's impact on a physician's success and efficiency may be even greater than he realizes, for it is the medical assistant who bridges what some have called the greatest communication gap in our society—that between the physician and his patients.

AAMA is attuned to the problems of modern medical practices. AAMA realizes practices that fail to treat today's patients with dignity and respect are in for a rude awakening.

Malpractice suits in all areas of health care are increasing. The majority of these suits arise from misunderstanding—real or imagined slights and neglects. A patient is less likely to file a suit against an office where he feels he has received professional, just, and courteous treatment.

Writing in St Paul Fire and Marine Insurance Company's *Malpractice Digest*, Neil Bernstein points out that by the time the patient walks into the examination room he has had the time and experience to form a prejudgment of the care he will receive. This prejudgment is related to such nonmedical factors as the appearance and management efficiency of the office and the level of knowledge and personal understanding displayed by staff members.

As agents of physicians, medical assistants should be thoroughly versed in medical law and ethics as they apply to the physician-patient and the medical assistant-patient relationship.

Toward that end, AAMA has recently prepared a fourth guided study program, *Law and Ethics for the Medical Office*. It describes legal and ethical responsibilities as they relate to the practice situation. It provides guidelines for defensive medical practice that can be assimilated by every health care professional working with the physician. While an understanding of the psychological and psychosocial needs of the patient was presented in AAMA's, guided study program, *Human Relations for the Medical Office*, the law and ethics program emphasizes the cause-and-effect relationship of meeting patient needs. The course offers legal defense procedures on professional liability suits, confidentiality and release of medical records, and preparation of court documents.

Farsighted and prudent physicians quickly learn that encouraging their medical assistants' educational growth and professionalism is an inexpensive way of promoting self-esteem, loyalty, and efficiency. Recognizing the contributions of medical assistants to our practices by supporting their active participation in AAMA is a simple way to enhance their proficiency and help reduce malpractice claims. With increased competence, medical assistants enable physicians to enlarge the scope and quality of their services. When we encourage the personal growth and development of our medical assistants, we also encourage them to tap their own potential and become more effective members of the health care team.

Commitment to high standards in certification, accreditation and continuing education is the hallmark of AAMA's professionalism. The three educational arms of AAMA—Certifying, Continuing Education, and Curriculum Review Boards—work constantly to help members increase their competence and the quality and scope of their services.

Besides the stimulation of peer interaction and prestige of belonging to a professional organization, AAMA offers organized educational activities, planned meetings, study groups, continuing education programs and workshops to broaden members' knowledge.

AAMA was organized in 1956; its primary objective is professional self-improvement, to enable each medical assistant to better serve the medical profession and the public. AAMA inspires its members to give honest, loyal, and efficient service, to improve their educational background, and to better serve their employers. It is to the physician's advantage to encourage AAMA membership.

Physicians depend upon medical assistants to manage their offices competently and efficiently. AAMA's potential membership is estimated at 300,000-500,000 members, yet its current membership is less than 16,000. With AAMA as its representative, medical assisting as a whole could be the strongest and most important allied health profession to physicians.

According to its bylaws, AAMA is not, nor can it ever become, a union or collective bargaining agency. In addition, the association has been commended by the American Medical Association on six separate occasions.

For further information, I encourage you to contact your state medical society or write to the American Association of Medical Assistants, One East Wacker Drive, Suite 2110, Chicago, Illinois 60601. The investment of your time today can result in physicians, medical assistants and patients *all* benefiting as AAMA helps its members fulfill their professional obligations.

Ralph E Hagan, MD
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WARNINGS

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PRECAUTIONS

General

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See "WARNINGS"

Pediatric Use

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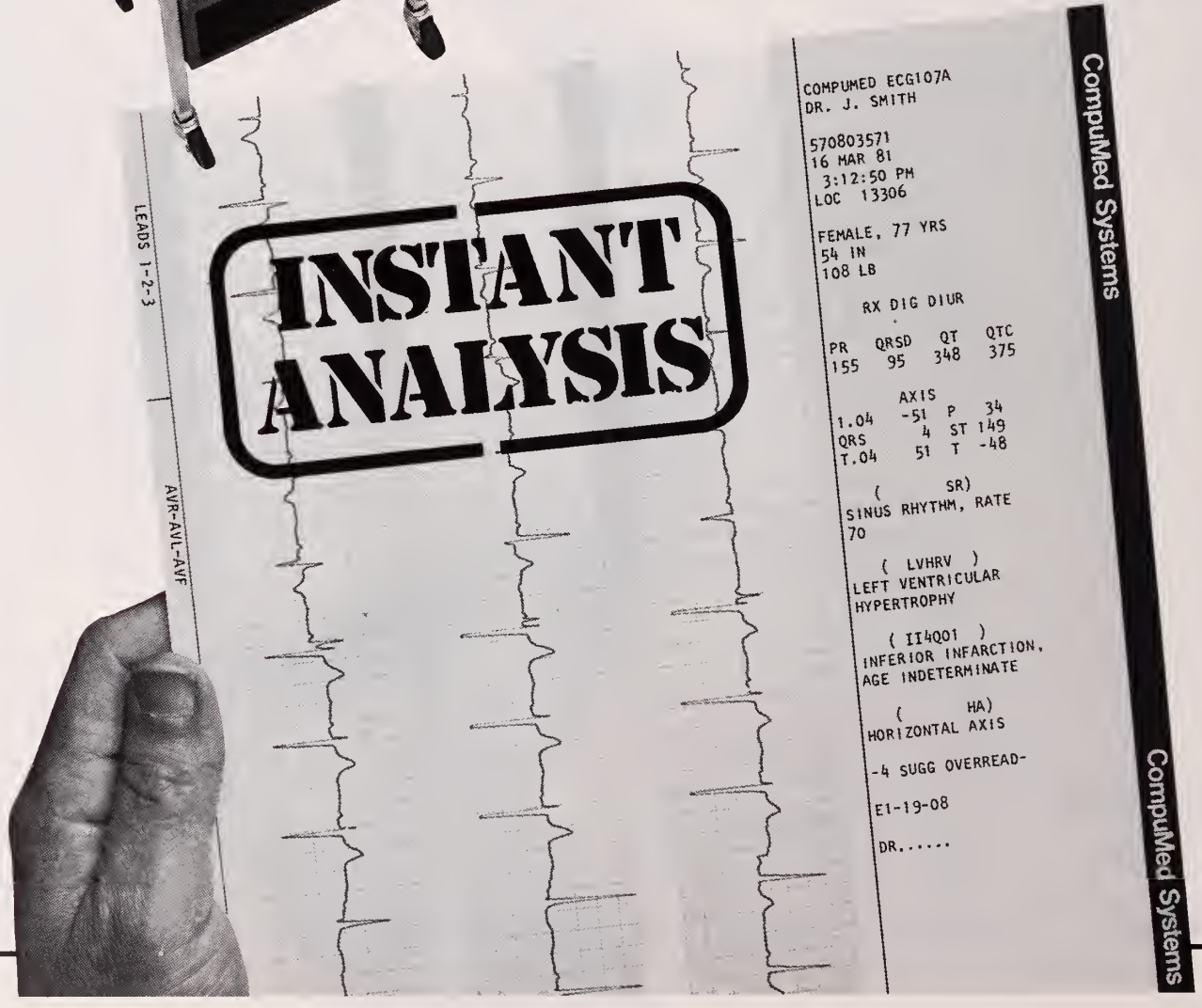

Geriatric medicine— a demographic imperative

Steven R Gambert, MD, Milwaukee Wisconsin

IT'S BEEN SAID that the post-war baby-boon was the generation that "greened" America in the 1970s and that it will go on to "grey" America in the 21st century. Although the population as a whole will double in the next 35 years, the number of those over the age of 65 will double in only 30 years and those over 75 years will reach 120% of their present population within this same period. Therefore, it is increasingly important that all health providers be particularly concerned and knowledgeable about the needs and specific problems of the elderly.

The "imperative" we now face embodies not only past and future growth in this segment of the population but also the expected change in the percentage of the elderly who are working and economic problems that must be solved to provide optimal social and healthcare services for the elderly. Now is the time to plan ahead and to anticipate manpower and service needs.

Perhaps the following points will give us a better understanding of the "imperative" we face:

• Within the elderly population, the fastest growing segment has been at the older ages. People aged 85 and over tripled in number between 1950 and 1980. Those aged 75-84 doubled in this same period. As one ages, chronic disabilities become additive and eventually synergistic.

• Although presently there are five working Americans for every American aged 65 and over not working, by 2035 it is anticipated that there will be only three working persons for every older American who is not working. This has obvious implications for financing social programs and Medicare benefits.

• Health costs are rapidly rising and presently are 9.2% of the Gross National Product. Although the elderly presently comprise 11% to 12% of the total population, they utilize approximately 30% of health costs. Economic implications are obvious if demographic trends continue. Unless some dramatic change occurs in current healthcare practices, significant attention to cost-effectiveness will be increasingly important.

• Because women live longer than men, and usually marry men older than themselves, there are more older women widowed than men. More older women live alone with smaller incomes.

• The elderly have a greater likelihood of residing in central cities than their younger cohorts. Many elderly also reside in rural areas far from geriatric social services.

• Approximately 25% of the elderly are officially classified as living at or below poverty level. The elderly spend relatively more of their incomes for food, housing, and health than younger persons.

• The majority of elderly are home owners and have to provide supporting services.

• At any one time, only 4% to 6% of the elderly reside in institutions. Most elderly reside in family households. Over age 65, 75% of men and 37% of women live with a spouse. Over age 75, 67%

DR STEVEN R GAMBERT conceived the idea of devoting an issue of the *Wisconsin Medical Journal* to gerontology. He then recruited the authors of the papers for this special issue and got the manuscripts together. This is no small task when dealing with a group of independent physicians. Doctor Gambert subsequently edited the manuscripts.

Doctor Gambert wears two hats in the field of gerontology. He is chief of the section of geriatrics and gerontology in the Department of Medicine at the Medical College of Wisconsin and chief of the geriatrics section of the medical service at the Wood VA Medical Center.

It is obvious that gerontology is increasingly important in the practice of medicine as the aging population continues to expand. The *Journal* staff is grateful to Doctor Gambert for suggesting and accomplishing this issue on gerontology.—VSF

Doctor Gambert is Associate Professor of Medicine and Physiology; Chief, Section of Geriatrics and Gerontology; Department of Medicine, The Medical College of Wisconsin; and Chief, Geriatrics Section, Medical Service, Wood VA Medical Center, Milwaukee, Wisconsin. Reprint requests to: Steven R Gambert, MD, Chief, Geriatrics Section/111P, Wood VA Medical Center, 5000 West National Ave, Wood (Milwaukee), Wis 53193 (phone: 414/384-2000). Copyright 1982 by the State Medical Society of Wisconsin.

A challenge for health providers

of men and only 20% of women live with a spouse Fifty percent of women aged 75 and older live alone as compared with 20% of men of similar age. Ten percent of those over age 75 and 22% of those over the age of 85 live in nursing homes.

- Illness and injury cause an average of 40 days of disability for the elderly person each year, nearly twice that of the general population.
- Elderly persons take longer to recover from an acute condition than do younger people.
- Accidents at home occur more commonly in the elderly.
- People in their late 60s spend 3.0 days; people in their late 70s, 4.7 days; and people aged over 85, 8.3 days in the hospital on a mean per year.
- Among noninstitutionalized elderly, almost half have arthritis, 20% heart disease, 20% hypertension, and 30% hearing deficits; 45% have some limitation of activity, compared to 15% for the general population. For those over 85, 60% are limited in their activities.
- Less than 2% of well, ambulatory need assistance with activities of daily living. For those elderly in nursing homes, however, almost 90% need help in bathing, 71% with dressing, 34% with eating, and 55% with toileting. These figures are directly related to the age of the elderly person.
- Men born today have a life expectancy of 69.4 years and women 77.3 years.
- In 1953, a 65-year-old person could expect to live another 14.0 years. The 65-year-old person of today can expect to live another 16.3 years.

It is obvious that the elderly are a rapidly increasing segment of the population, and that now is the time to plan to meet the medical, social, and economic challenges ahead. The articles in this special issue discuss several problems commonly found in the elderly. These papers are in no way meant to be exhaustive reviews of the literature, but they are all written by recognized specialists in the field of Geriatrics and Gerontology. We are indebted to the Editorial Board of the *Wisconsin Medical Journal* for agreeing to publish this forum and hope that you, the readers, will help us to meet the challenges that lie ahead for us all.■

Nutritional assessment in the elderly

Steven R Gambert, MD, Milwaukee, Wisconsin

NUTRITIONAL ADEQUACY is basic for survival and for the maintenance of health throughout life. It is presently believed that all individuals require the same nutrients throughout life. Only the amounts required vary with age, activity, sex, and physiologic state.

Often the elderly face changes in life style, economics, and mood that lead to altered nutritional states. In addition, normal aging is associated with numerous physiologic changes that may affect how food is absorbed, utilized, and byproducts excreted. For these reasons, health professionals must be able to clinically assess existing states of nutritional inadequacy as well as anticipate future problems that may arise due to poor nutritional intake.

Physiology of aging. It is imperative that the clinician realize that even if the elderly person's diet contains all of the necessary nutrients, it may not be enough to assure nutritional adequacy. The normal aging process involves a number of physiologic changes that can influence one's nutritional status. In terms of nutrition, the most important of these physiologic changes relate to the neuromuscular, gastrointestinal, and renal systems. With advancing age, motor function generally declines. Both the actual number of functioning muscle fibers as well as the contractile process itself are affected.[1] Chewing can present a prob-

Doctor Gambert is Associate Professor of Medicine, Department of Medicine, The Medical College of Wisconsin; and Chief, Geriatrics Section, Wood VA Medical Center, Milwaukee, Wisconsin. Reprint requests to: Steven R Gambert, MD, Chief, Geriatrics Section/111P, Wood VA Medical Center, 5000 West National Ave, Wood (Milwaukee), Wis 53193 (phone: 414/384-2000). Copyright 1982 by the State Medical Society of Wisconsin.

lem as well as finding the energy to shop for oneself.

Changes in body composition also play an important role. Fat content doubles between the third and ninth decades of life.[2] Nutrients which are highly fat soluble, such as vitamin D, will have a greater tendency to be distributed in the body and potentially lead to toxicity. Persons with a high vitamin D content in their diet may present with increasing hypercalciuria and even hypercalcemia with advancing age merely on the basis of this greater vitamin D distribution. Recent studies have now shown that fat cell number is not fixed early in life, but that proliferation is on a continuum; and thus the potential for troubled weight loss exists throughout life.

The mineral content of bone declines steadily throughout life. This decline is most apparent in white women of Anglosaxon origin and least apparent in black males. This is primarily due to a higher starting bone mass in the latter group. A diet containing sufficient calcium is essential throughout life to help retard bone mineral loss and prevent negative calcium balance. Cross-sectional studies of aging populations have shown a decline in lean muscle mass.[3] Recent data from the National Institute on Aging and the Baltimore Longitudinal Study suggest that individuals with less initial lean muscle mass and a body weight 10% to 20% over ideal may actually live longer.

Gastrointestinal function also changes with age. The ability of the parietal cells to secrete hydrochloric acid declines. A simple example of how this might effect one's nutritional status is the necessity of an acid environment to convert the dietary form of iron, ferric, to that form which is absorbed, ferrous. Therefore, the elderly may become deficient in iron despite an apparently adequate intake and over a long term present clinically with anemia. With age there is a general reduction in the secretory ability of the digestive glands making food utilization often less than ideal. Lactose deficiency occurs commonly in the elderly and often histories of deficient dairy intake can be traced to a degree of intolerance in the past. There is a decline in the ability to absorb calcium after the seventh decade further contributing to a negative calcium balance in elderly individuals. Perhaps one of the most important contributors to nutritional inadequacy in the aged is the steady decline in the number of taste buds[4] and sense of smell making food less desirable.

Renal function normally declines approximately 0.6% per year.[5] It is important that a false sense of confidence not be obtained by seeing a serum creatinine of 1.0 in the elderly. Due to a decrease in lean muscle mass in elderly persons, a creatinine of 1.0 in an 80-year-old person may very well represent 60% of normal creatinine clearance. Nutrients must not only be absorbed and utilized but also toxic byproducts must be excreted; and therefore, an age-related decline in renal function may result in potential problems. The normal process of aging is complex, universal, progressive, and at least as we know it today, irreversible.

Protein requirements in the elderly. Protein requirements for the elderly are still a matter of great controversy. The present recommended daily dietary allowance for protein is 0.8 Gm protein/kg body weight.[6] Although this represents approximately 9% of the caloric intake in young individuals, due to a general decline in caloric requirements with age, this represents 12% to 14% of the elderly person's diet. Those who argue for less protein intake in the elderly site the decline

in renal function as a major reason. They are concerned over the inability to adequately excrete toxic byproducts and are afraid of metabolic alterations resulting from too high of a solute load from proteins. Those who advocate an increased protein intake for the elderly argue that the elderly have a decreased ability to digest protein; and therefore, a higher intake will ensure adequate protein as well as mineral and iron content due to the fact that protein-containing foods are generally nutritionally sound.

Protein-calorie malnutrition (PCM) is the most undiagnosed nutritional disorder in the world today and is found in all social and age groups.[7] Although most prevalent in young children, it can develop at any age whenever prolonged consumption of a diet high in carbohydrates and low in protein is consumed. PCM may affect from 25% to 50% of medical and surgical patients for whom the duration of hospital stay is longer than two weeks.

The elderly are particularly prone to the possible effects of PCM. Besides the effects of multiple hospital admissions, the home diets of many elderly persons are often nutritionally inadequate with respect to vitamins, minerals, and proteins.[8] As mentioned above, multiple causes can usually be blamed for this nutritional inadequacy. Poverty, isolation, and dietary ignorance are key factors.

Proper food utilization may be affected not only by normal aging changes but also diseases of the oral cavity, poor dentition, and disease of the gastrointestinal tract. Problems with food absorption, utilization, storage, or digestion can be severe enough to result in PCM despite proper dietary intake.

Protein deficiency impairs mechanical, cellular, and humoral immunologic defenses. In addition, PCM results in psychomotor changes, edema, and muscle wasting despite the preservation of subcutaneous fat. Hepatomegaly is common, and fatty infiltration of the liver may be severe. Usually signs of multiple nutritional deficiencies can be seen. Histologic examination may reveal a decrease in pancreatic size in association with local edema and loss of normal cellular architecture. Pancreatic exocrine cells show decreased cytoplasm, fewer zymogen granules, and altered arrangement of acinar cells.[5] An abnormal glucose tolerance test may result due to poor beta cell function.[9,10]

Table 1—*Signs and symptoms of nutritional inadequacy*

General Appearance	Thin? Obese?
Skin	Pallor, hyperkeratosis, bruises, dermatitis, fistulas, edema, abnormal pigmentation, subcutaneous fat and skin-fold thickness.
Eyes	Ophthalmoplegia, cataracts, xerosis, night blindness, Bitot's spots, retinal hemorrhage, papilledema.
Mouth	Glossitis, gingivitis, cheilosis, dysgeusia, ageusia, peridontal disease, caries.
Nose	Nasolabial seborrhea, anosmia, dysosmia.
Hair	Sparseness, depigmentation, easy-pluckability.
Nails	Friability, bands, lines.
Neck	Goiter.
Cardiovascular	High output failure, cardiac enlargement, resting tachycardia.
Lungs	Breathing with accessory muscles.
Abdomen	Enlarged liver, ascites, varices.
Skeletal	Tenderness, epiphyseal thickening, bowing, rachitic rosary, osteoporosis, frog leg position.
Muscle	Atrophy, pain.
Joints	Arthralgia, effusions.
Neurological	Hyporeflexia, irritability, convulsions, foot drop, decreased position and vibratory sense, confabulation, hyperreflexia.

Table 2—*Laboratory assessment of nutritional inadequacy*

Hemoglobin	Urinary nitrogen/ creatinine ratio
Hematocrit	Serum carotene
Serum iron/transferrin	Prothrombin time
Serum protein	Serum vitamin levels
Serum albumin	Glucose tolerance test
Blood urea nitrogen	

Nutritional assessment for the elderly. It is imperative that all health professionals actively seek to prevent nutritional inadequacy in the elderly. A thorough nutritional evaluation should be a routine part of every geriatric patient's initial examination and periodic follow-up.

The following is suggested as a guide which if incorporated into one's clinical routine can assess not only existing nutritional deficiences but also enable the clinician to anticipate future nutritional problems that are likely to develop.

History:

1. *Eating is a social behavior.* Elderly persons who have recently lost a spouse and are now living alone are at high risk for nutritional deficiency. Senior citizen centers may provide a social outlet and should be encouraged if friends or family are not nearby and/or supportive.

2. *Economic hardships should not be taken for granted.* Recent studies have shown that a large number of elderly subsist on $1.66 per day after spending money on rent, drugs, and clothes. Subsidized meals may be essential; meals on wheels in itself does not guarantee the elderly person's willingness to eat and should not prevent the clinician from further assessing nutritional status.

3. *Food source.* Does the elderly person shop for him/herself or does someone bring food to the home? It is imperative that a supply of nonperishable food be on hand in anticipation of illness, severe weather, or other unforseen problems.

4. *Diet history.* Although often unreliable, general likes and dislikes can often provide clues to nutritional problems.

Physical Exam:

1. *Height and weight must be taken.* History alone leads to great inaccuracy especially in the elderly who often site their measurements as those when they entered military service or graduated from high school. Measurements obtained should be compared to "ideal" body weight and height as normalized for age.[11] Weight loss or gain is extremely important. Rapid weight loss implies more of a loss from muscle mass and reflects the use of endogenous protein as a fuel source. Adi-

pose tissue is lost more slowly because of its higher caloric content. It is important to remember that an obese person may still remain overweight despite severe protein calorie malnutrition. In addition, weight alone can be misleading. The cardiac cachetic may maintain body weight due to edema fluid, despite anorexia and a significant loss of muscle mass.

2. *Skinfold thickness:* Measurements of skinfold thickness at various body sites has proved to be a helpful indicator of nutritional status. The clinician grasps a fold of skin and while gently pulling it away from the underlying muscle, measures its thickness using either a Lang or Harpendeir skinfold calipers. The average of several readings is recorded and may serve as a comparison to future readings. Normal values have been established; however, these must be corrected for age.

3.*Mid-arm circumference:* This measurement reflects both caloric adequacy and muscle mass. A soft tape measure is used to determine the circumference of the nondominant mid-upper arm. An index is derived by use of the Jeliffe formula. Although normal values have not been standardized for the geriatric age group, serial measurements can be used to assess changes in nutritional status on an individual basis.

In summary, the elderly are particularly prone to the development of nutritional inadequacies due to both physiological and psychological factors. Health professionals must be aware of the widespread nutritional problems existing in so many of the elderly and actively participate in prevention. A nutritional assessment should be part of every elderly person's initial examination and periodic follow-up. The "tea and toast crowd" must be identified and guided to a better nutritional existence.

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Drug Usage in the elderly

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THE ELDERLY CONSTITUTE a growing segment of our population. Although persons over age 65 constitute 10% to 12% of the total population, they use about one quarter of all prescribed and over-the-counter drugs. Elderly persons use more drugs for several reasons. They have multiple chronic problems involving more than one organ system which may require long-term and continuous drug therapy prescribed by one or more physicians. Elderly persons undergo stress resulting from social and economic changes. They may come to the physician with vague, recurring symptoms arising from loneliness and feelings of rejection. The older person and/or the family may pressure the physician for a prescription to ease the situation and accompanying stress.

The extent of drug usage by the elderly differs if the person lives in the community or in a nursing home. It was reported in a recent study[1] that elders in a nursing home take more medications than the noninstitutionalized. An important consideration when reviewing literature about drug usage is to ascertain if "average number of drugs consumed" includes both over-the-counter (OTC) and prescription medications. It is possible to draw an inaccurate picture of drug usage if this point is not borne in mind. In general, sedatives, hypoglycemics, diuretics, hypnotics, digoxin and propoxyphene are most often prescribed for the

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elderly.[2] Laxatives and aspirin-containing preparations are most often self-prescribed.[3]

A large number of OTC drugs are available in drug stores, supermarkets, and through the mail. Elderly persons try these medications because they do not want to "bother the doctor," or feel that they can manage their symptoms through self-medication. Use of these preparations can interfere with a therapeutic regimen and bring about a higher incidence of adverse drug interactions.

As the result of multiple drug therapy, as well as physiological changes in the way the aging body handles drugs, the aged have seven times as many adverse drug reactions as do younger patients.[4,5] These reactions can require hospitalization or prolong hospital stays adding unnecessary costs to patient care. More importantly, many reactions are unpleasant, and may on occasion result in death.

Noncompliance with proper drug utilization is as important as, if not more important than, the problems of adverse drug reactions and interactions. Blackwell, in reviewing more than 50 studies, found that complete failure to take medication often occurred in mo than one-half of all outpatients. Other types of poor compliance, which may be more frequent, include taking medication for wrong reasons, errors in dosage, and mistakes in timing or sequence.[6]

Pharmacokinetics and pharmacodynamics. A number of factors that might be expected to affect drug pharmacokinetics and response in the elderly are listed in Table 1.[7] Elevated gastric pH, delayed gastric emptying, reduced intestinal blood flow could affect absorption after oral administration. Available data are limited, but they do not indicate a significant alteration of drug absorption in the elderly.[7]

Because the old are more likely to receive multiple drugs, absorption may be affected by drug interactions. For example, a drug which speeds upper intestinal transit will cause digoxin to be less rapidly and less completely absorbed because the digoxin is hurried over the absorptive surface. Conversely, a drug such as propantheline (Pro-Banthine®) will increase the absorption of digoxin by prolonging contact with the absorptive surface. More direct effects are seen when tetracylines combine with metal ions such as calciums, magnesium, aluminum, and iron to form insoluble complexes and thus impair maximum absorption.

Table 1—*Summary of factors affecting drug disposition and response in the elderly**

Effect	*Altered physiology*	*Clinical importance*
Absorption	Elevated gastric pH Reduced GI blood flow ? Reduced number of absorbing cells	Not sufficiently studied
	? Reduced GI motility	
Distribution	Body composition Reduced total body water Reduced lean body mass/kg body weight Increased body fat	Higher concentration of drugs distributed in body fluids ? Longer duration of action of fat soluble drugs
	Protein binding Reduced serum albumin	Higher free fraction of highly protein-bound drugs
Elimination	Hepatic metabolism Reduced enzyme activity Reduced hepatic mass Reduced hepatic blood flow	Apparently slower biotransformation of some drugs Influenced by environmental factors (*eg,* nutrition and smoking)
	Renal excretion Reduced glomerular filtration rate Reduced renal plasma flow Altered tubular function	Slower excretion of some drugs
Response	Multiple disease states Multiple drug use common Altered receptor sensivity Organ specific age differences	More variation in dose response Adverse drug reactions

*From Vestal.[7] This table is reproduced with author's permission.

Drug distribution has been shown to be affected by age. There is a decrease in total body water and hence alteration in volume of distribution of some drugs. Lean body mass is also diminished while body fat increases. Drugs that are distributed mainly in body water or lean body mass might have higher blood levels, particularly if the dose is based on total body weight or surface area. For example, ethanol is hydrophilic and researchers have observed higher peak blood levels in older subjects for a given dose without a difference in the drug's metabolism.[8] Lipid soluble drugs such as diazepam and barbiturates reflect age-related alteration in distribution space. With diazepam, unlike ethanol, there is an increase in distribution space, since body fat increases with age.

Another factor which affects drug distribution is protein-binding capacity. Many drugs are bound to a greater or lesser degree to the albumin fraction in plasma. Since only the unbound portion is pharmacologically active, the bioavailability of these substances varies inversely with the degree of binding. Increased amounts of unbound drug make more drug available for increased pharmacologic effects. Phenytoin, tolbutamide, salicylate, phenylbutazone and sulfadiazine show decreased protein binding with increased age.[9] The presence of other drugs competing for the same binding sites can further complicate therapy. For example, a patient stabilized on tolbutamide may suffer drug-induced hypoglycemia if a high binding drug such as salicylate or phenylbutazone is added.

Drugs are removed from the body in two ways: (1) liver metabolism to less active or inactive metabolites, which are usually excreted by the kidney, or (2) excretion of unchanged drug by the kidney. Both of these processes may be affected by the aging process.

In general, clearance is a better measure of intrinsic liver drug-metabolizing activity than half life ($t_{1/2}$), since the latter is a function of both clearance and distribution volume. The body's ability to metabolize drugs is affected by genetic influences and exposure to other substances such as alcohol,[8] tobacco,[10] and insecticides.[11] The latter factor may be of great import to future aging cohorts.

Evidence for age-related effects on microsomal activity in human liver is inadequate. However, indirect evidence based on plasma half-lives or clearance of drugs metabolized extensively in the liver corroborates the findings of reduced hepatic microsomal induction with aging in laboratory animals.[7] It is reasonable to assume at least some reduction in drug biotransformation in the elderly and to expect therapeutic results to be influenced by this. More data are needed in this regard.

A role for nutrition in the decline of hepatic metabolizing capacity has been suggested. Early clinical investigations compared elderly patients having normal vitamin C, folate, and vitamin A levels with elderly patients' deficient in these vitamins. Results found almost normal drug half-lives for the first group, but significantly longer half-lives in the comparison (deficient) group.[12]

There is no doubt about the importance of reduced renal excretion in older adults. Renal function measured as either total renal blood flow, glomerular filtration rate, or tubular excretory capacity may show a "normal" decline of 40% to 50% between the third to ninth decade.[13] Renal function may be further impaired in the elderly due to dehydration, hyper- or hypotension, heart failure, diabetes or obstructive uropathy, to name a few. Those drugs eliminated primarily by the kidney; *eg,* digoxin and aminoglycosides must be used with the knowledge that potentially toxic levels may occur unless dosages are adjusted in light of reduced renal function.

Serum creatinine, the most commonly used index of renal function, may remain virtually constant in the elderly despite the marked reduction in renal function. Loss of lean body mass that occurs with aging causes decreased creatinine production. Therefore, the reduced renal function is not reflected by a rise in serum creatinine. When interpreting serum creatinine levels in the elderly, vis-a-vis younger or middle-aged adults, this point must be recalled. Therefore, creatinine clearance is the only accurate way to access impairment of function. Nomograms, formulae, or actual measurement of the clearance can all be employed to accomplish the same goal.[14,15,16] The equation developed by Gault and Cockcroft[16] can be utilized to rapidly estimate creatinine clearance in persons with stable renal function.

$$\text{Creatinine clearance (ml/min)} = \frac{(140\text{-age}) \times \text{weight (kg)}}{S_{creat}\ (\text{mg/dl}) \times 72}$$

With diminished renal and hepatic function, plasma half-life may be prolonged, increasing the risk of drug toxicity and drug interactions.

Target Organ Sensitivity. Sometimes an increased drug effect is due to a greater sensitivity of receptor sites in old people. It is believed that physiological decline in autonomic function, occurring with age, interacts with other factors such as the administration of hypotensive drugs to produce postural hypotension in old age.[17] Age related decline in autonomic function also accounts for the greater liability of the elderly to develop hypothermia under conditions of cold stress,[18] and this impairment of temperature regulation contri-

butes to the increased susceptibility of elderly to the hypothermic effects of the phenothiazines. Phenothiazines are believed to inhibit noradrenergic and dopaminergic receptor sites in the central and autonomic nervous systems.[19] Studies have demonstrated an increased sensitivity to the effects of various benzodiazepines in the elderly.[20,21,22] By contrast the elderly have been shown less sensitive to the chronotropic effects of isoproterenol and the beta-blocking effects of propranolol.[23] While it is generally assumed that the aged will be more sensitive to drug effects, this does not necessarily hold for all drugs. Rather, the opposite may be true.

Basic Principles of Therapeutics in the Elderly. Drugs must be used cautiously in older people. To manage therapy safely, the following general rules should be observed:

1. ***Determine whether the person actually needs drug therapy.*** Risks must be weighed against benefits.

2. ***Take a careful drug history.*** Older adults are likely to have multiple problems and be taking multiple medications. Do not overlook self-prescribed and OTC drugs. The elderly may be under the care of more than one clinician and may be receiving two or more drugs with similar side effects. Additive effects or antagonistic action can result from concurrent use of drugs.

3. ***Be informed and current about the pharmacokinetics*** as well as actions, side effects, and toxicity of drugs prescribed (these may be different in the elderly than the middle-aged.)

4. ***Adjust drug dosage according to patient response.*** Identify those signs or symptoms you wish to monitor for drug effectiveness. In general, use smaller doses than are usually given to younger adults. Dosage schedules should be simple. Intermittent schedules should be avoided. Once-daily dosage is ideal.

5. ***Provide medication instructions to both the patient*** and or family or friend. Explain the reasons why the drug is being prescribed, what effects are expected, which side effects indicate developing problems, and what to do when side effects occur or the drug is ineffective. Reinforce your teaching with written instructions. Supervision of therapy by Public Health or Visiting Nurses may be indicated. Various methods of fostering drug compliance may be utilized; *eg,* calendars cards, setting pills out in advance. All prescriptions should be clearly labeled in large print and packaged in readily opened containers. Child-proof containers may prevent the older arthritic from complying with drug regimens. Special instructions to the pharmacist from the physician will insure that drugs are not dispensed in child-proof containers. In addition, one should not overlook the pharmacists' role in providing and reinforcing drug information for patients.

6. ***Regularly review the drug regimen*** and discontinue those not needed. Encourage the older person to discard old unused medications. This minimizes confusion about treatment, and fosters compliance.

7. ***Be alert to drug-induced illness.*** Unusual symptoms may be explained by drug therapy gone awry.

8. ***Expect that noncompliance will occur,*** and tell the older person what to do if doses are missed.[24] Such anticipatory instruction may prevent overdosing if the older person decides to "catch up" by taking all missed doses at once.

Summary. This article has superficially discussed multiple drug therapy, pharmacology of old age, factors affecting compliance and general rules for prescribing. An important topic not covered was the hazards posed by particular groups of drugs; namely, digitalis, diuretics, beta blockers, other antihypertensive drugs, anticoagulants, analgesics, sedative-hypnotics, tricyclic antidepressants and antipsychotics, and antiparkinsonian drugs. Concern about drug interactions, drug-drug or drug-food was only touched upon. Another area in need of in-depth consideration involves drug therapy in nursing homes. The references[2,7] provide a more detailed discussion of the main areas mentioned.

Problems in geriatric drug therapy are recognized by health professionals working with the elderly. Clinical pharmacists and pharmacologists can provide in-depth information about pharmacokinetics and pharmacodynamics and how these processes are affected by age.

Consultation and interdisciplinary collaboration can be invaluable in managing all aspects of geriatric care. Other professionals knowledgable about aging and the aged include geriatricians and gerontological nurses. Social workers assist elderly with concerns about finances and living arrangements, both of which can adversely affect the aged person's compliance with drug regimens.

Conclusion. A careful and thoughtful approach to drug use with elders is essential if appropriate therapy is to be prescribed. Drugs are hazardous to elders because of age-related or altered physiology and pharmacokinetics, the high incidence of drug interactions, inappropriate prescribing practice, inadequate monitoring of long-term medications, and inaccurate patient compliance. Choosing a safe and effective course of drug therapy, balancing drug use benefits and risks, calls

for special vigilance and skillful management by the physician. Just as the elderly are especially prone to suffer ill effects from injudicious drug therapy, so also they are the greatest beneficiaries of its correct use. Population trends make it inevitable that physicians will be increasingly involved with elderly persons. This emphasizes the need for understanding the complexities of drug therapy and geriatric pharmacology.

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The assessment of rehabilitation potential in the elderly

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RESTORATION OF maximum function is the ultimate goal of rehabilitation for people of all ages. In the young the return to gainful employment is the goal; whereas, in the older person self-sufficiency in ambulation and activities of daily living is the primary goal. When assessing the elderly patient for rehabilitation potential, we must keep in mind the relative nature of rehabilitation. If we can improve personal functioning in the presence of illness and physical disabilities, rehabilitation is worthwhile.[1] Age alone should not be a deterrant to rehabilitation, neither should the presence of multiple medical problems and physical disabilities. Even the most disabled have some remaining abilities that can be utilized in improv-

An 84-year-old blacksmith who does not believe in retirement

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ing function. The emphasis should be on residual capacity, not disability.

An accurate assessment of a patient's capacity is necessary for determination of prognosis, for developing an appropriate treatment program, and for measuring progress.[2] In assessing the geriatric patient, we must take into account the four major aspects in a person's life that will have an influence on the rehabilitation process and outcome: (1) physical condition and impairment, (2) mental capacity and psychologic reaction to disability, (3) social situation, and (4) economic factors.[3]

In the elderly multiple pathologic processes occurring in several systems simultaneously are not uncommon. Reduced physiologic reserves are depleted by the stress of a disabling illness. Cardiorespiratory function and degenerative joint changes will influence exercise tolerance. Before undertaking an active rehabilitation program, the patient's cardiorespiratory function must be known. History of heart disease, medications, cardiac rate and rhythm, blood pressure, and response to exercise must be taken into account when prescribing an exercise program. The extremities must be carefully inspected for the presence of peripheral vascular disease. Obstructive pulmonary disease is common in the elderly and will reduce exercise tolerance. All these problems are not contradictions to rehabilitation but will influence the type and pace of the program. In fact, cardiorespiratory function can be improved with exercise at any age.

Still writing

Skeletal and joint disorders must be noted. Osteoporosis is common in elderly women. Degenerative joint disease is universal in the elderly. Both disorders can limit an exercise program but will also benefit by it. Pain is frequently a factor in these disorders and must be treated before rehabilitation can progress. A thorough neuromuscular examination is essential. Vision and hearing should be tested and impairments corrected if possible. Special approaches will have to be planned for the blind and deaf. Other sensory modalities should be thoroughly tested. Impaired perception of pain, touch, proprioception, and spatial orientation will greatly interfere with motor function.

Joint range of motion and muscle strength of the limbs as well as flexibility of the spine, balance, and posture should be assessed. More important, however, in determining neuromuscular function is the observation of the patient in the performance of activities of daily living. Observation of gait can be more informative than a formal neurologic examination.[4] How a person performs such simple activities as dressing, eating, and hygiene provides clues about his motor, sensory, and cognitive functioning. Condition of the skin, nutritional status, and bowel and bladder control can also influence the success of the rehabilitation program. A poorly nourished, incontinent patient with bedsores will have poor exercise tolerance, but he need not be denied therapy. Proper attention to the multiple collateral physical problems in the disabled geriatric patient will greatly facilitate the rehabilitation process.

Mental capacity and psychologic adjustment are highly important in determining how a physical disability will affect a person's functioning. Mental barriers to recovery are: (1) inability to learn, which may be due to aphasia or impaired memory, (2) disturbed perception, (3) disordered integrative action, such as apraxia, agnosia, and perseveration, and (4) disturbed emotion. In assessing mental capacity we need to look at appearance, mood, comprehension, concentration, insight orientation, speech, memory, and behavior. Observation of the patient in the performance of self-care activities and his interaction with staff and other patients, will give insight into the mental and emotional status of the patient.[4] Formal neuropsychologic testing is rarely indicated but can be very helpful in determining rehabilitation potential.

The third aspect of a person's life that will influence rehabilitation is social status. Supportive family and friends are very important in motivating the patient and speeding up recovery. Educational and vocational background as well as avocational interests can have a positive effect on the outcome of rehabilitation even in the geriatric patient who is no longer gainfully employed. The history should include inquiries about past education, employment, interests, and availability of family, friends, and other community support systems. The *sine qua non* of rehabilitation is motivation[5] and a patient who has a strong social support system and who is encouraged to utilize his past experiences and interests in his rehabilitation will do well. Lastly, we must remember to relate the geriatric patient's function to his environment and economic status. The history should include details of the physical home environment such as presence of stairs, rugs, railings, bathroom and kitchen layout, width of doorways and hallways, transportation availability. The simple, commonplace details are very important in the assessment of the disabled person and in the ultimate achievement of independence.[2]

Much can be expected of elderly people in spite of disability.[2] Chronologic age per se is not closely

correlated with successful outcome in rehabilitation. Physiologic age is more significant. Rehabilitation can favorably influence the life of elderly people in ill health and will frequently permit patients to remain in their home environment and they need not be relegated to the limbo of custodial care.[6]

It is imperative to make a detailed assessment as early as possible and to initiate therapy rapidly in order to prevent secondary disabilities. We must also remember to persist with treatment longer, since elderly patients often make unpredictable improvement with prolonged persistent treatment.

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Health, stress, and coping in the elderly

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THERE IS THE STORY of a cheerful old man who regularly was seen begging in the park. He had a sign hanging from his neck that read: *Help a poor old man.* He was very cheerful, courteous, and smiled to all who passed. A minister who had been observing him was puzzled. He walked over to the beggar, gave him some money, and said, "Tell me, my friend, have you no family?" "Of course I have a family," answered the beggar. "And children?," asked the minister. "Oh yes, five children—all grown and well to do," replied the beggar. "And they won't support you?," asked the minister. "They would if I let them," answered the beggar. "Well, then, why don't you?," cried the minister. "What," retorted the beggar with indignation, "and lose my independence?."

Growing old in a youth-oriented society that places primary value on independence, competence, energy, and productivity is not easy. It is the primary adaptive task of old age to find satisfaction and self-esteem when role loss, social status loss, and physical ailments are more noticeable and decrements more likely than ever before.

The hallmark of dignity and adulthood in Western culture is independence. Youngsters yearn for the day when they can be independent; adults cherish their independence, and old people fear for the time when their frailties will jeopardize their independence through loss of competence. White[1] chose the word competence to explain the enormous thrust of human behavior to acquire the capacity to interact effectively with the environment. Effective interaction is learned continuously across the life-span, from the earliest experiences of succorance in infancy to the last experiences of frailty and decline in old age. Competence, therefore, is necessarily an inherent part of one's self-esteem, beginning as a basic survival skill and later transformed into a core value in one's assessment of worth. Despite continuous changes in physiological structures, in mental and emotional function, and in the emergence and loss of social roles, normal persons have the adaptive capacity to maintain an overriding sense of sameness and continuity as they age, provided that their abilities to function competently meet their expectations.

The assessment of competence comes not merely from an objective evaluation of one's physical ability or cognitive skill in performing certain tasks. There is a subjective component that stems from the fact that self-esteem is central to all human action. We maintain our self-respect by behaving in ways that meet the expectations of those who are significant to us and share our cultural codes.[2,3] Every psychological event of information-processing involves the cognitive act of representing both the environment and the self. In other words, implicit in any act of knowing is the self and its relationship to what is known.[4] Similarly, data from studies of interpersonal interaction have shown that an individual's perception of the behavior of another person always involves one's impressions of self, one's state of mind at the time, and one's previous experiences.[5] The self is not only deeply involved in all behavioral interactions, it is actively shaping the meaning of the experience. Indeed, in all activities this process involves conceptions of self that are represented in esteem, identity, and competence as well as extensions of self that are reflected in one's values,

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goals, and intentions. An understanding of human development must attend to these processes by which meaning is constructed. Practitioners who work with the elderly must pay particular attention to their patients' sources of meaning and self-esteem. These patterns are relatively stable, having been created over a life time of experiences, but the psychological resources of many elderly to sustain meaning and self-esteem may be compromised by problems of poor health and stress. The purpose of this paper is to explore several major components of health, stress, and coping within the context of developmental psychology and practitioner sensitivity to the issues of competence in the elderly.

Health and activities. No other characteristic is as pervasively influential as health in determining the capacity of the individual to function, adapt, and problem solve. On the conscious level it is recognized by all adult age groups as a component of importance to one's quality of life. At ages 30, 50 and 70, better than 90% of the men and women in each age group participating in a national survey identified *health and personal safety* as important or very important to their quality of life.[6] In fact, this variable received the highest percentage of responses in every age group for both sexes, with the exception of the 50-year-old men, where it took a close second to work.

Palmore and Luikart[7] found that self-rated health had a zero-order correlation twice that of any other variable when related to life satisfaction for men and women, accounting for the great majority of the explained variance in life satisfaction. In elderly the relationship of health to psychiatric symptoms is also highly correlated. Lowenthal and Berkman[8] reported that over half of their mentally impaired hospital sample of elderly reported psychiatric symptoms "primarily, often exclusively, due to physical illness or impairment" (p 7). Even persons suffering primarily from psychogenic disorders had more physical impairment than the nondisordered subjects.

A volunteer retired person showing school children how to make arts and crafts

However, despite the many chronic health problems faced by elderly patients, studies show that most elderly believe they are in better health than their contemporaries. Such subjective evaluations of one's health seem to be more important in motivating activity than the impact of medical opinion, because people tend to restrict their activities and social participation on the basis of how they feel.

Shanas[9] found that discrepancies between self-reports and objective measures of health are accounted for by the fact that older people assess their health on the basis of their ability to function independently rather than on the basis of whether or not disease or limitations are present.

There is great variation in the aging pattern of the elderly population. With age physical, emotional and social variables become increasingly interdependent in determining well-being. The General Accounting Office used the OARS Multidimensional Functional Assessment survey instrument[10] to determine the well-being status and impairment level of older persons in Cleveland. The OARS survey asks questions in five areas of human functioning: social, economic, mental, physical, and activities of daily living. The results in each area are combined to form a picture of overall well-being. The scale begins with "unimpaired," which means excellent or good in all five areas of human functioning. At the other end of the scale, "extremely impaired" means mild or moderate impairment in four areas and severe or complete impairment in the other, or complete impairment in two or more areas.

The GAO prepared special calculations based on its Cleveland study to show the relationship between advanced age and a decline in well-being status. It notes the almost doubling in the "extremely impaired" rate between the 75-79 age group and the 80-84 group (Table 1).

Physiological change and mental health. Numerous studies on the physiological changes that accompany normal aging indicate that structural and functional changes usually occur gradually. These changes are not necessarily reflected in impairment, but rather in the range of adaptability available to meet environmental and internal changes. Due to a steady decline in the functional capacity of cells, tissues, organs, and systems,[11,12,13] in the majority of the elderly, physiological changes in response to stress are greater and the rate of return to equilibrium is slower than in the younger subject.

Table 1—*Detailed break-down of well-being status by age*

Well-being status	*Under 70*	*70-74*	*75-79*	*80-84*	*85+*
Unimpaired	25.8	20.5	14.9	8.7	9.2
Slightly impaired	25.1	25.0	15.7	15.0	11.2
Mildly impaired	19.2	19.5	21.0	21.4	22.5
Moderately impaired	13.7	12.1	22.6	17.9	14.3
Generally impaired	5.4	10.8	9.3	11.6	12.2
Greatly impaired	1.9	2.9	3.6	2.9	2.0
Very greatly impaired	2.6	2.4	3.6	4.6	6.1
Extremely impaired	6.3	6.8	9.3	17.9	22.5
TOTAL	100	100	100	100	100

In addition to the physiological aging processes that affect the brain, in many cases the brain has been subject to trauma in earlier years due to childhood disease, high fevers, accidents, and poor nutrition. The brain is made up of billions of brain cells, however, and may sustain losses for many years without showing signs of impairment. Satisfactory functioning depends on maintaining a critical mass. Should this critical mass drop below a certain point because cells in the cortex of the brain change, malfunction or die, it results in a deficit that is called a brain syndrome.[14] This is characterized by disorientation in time and place, memory loss, deficits in computational ability, and in general information level. Although a temporary disease state may bring on brain malfunction with all the observable signs of a chronic brain syndrome, the critical mass necessary for adequate functioning is not reduced to a level of chronic impairment. As the disease state subsides the organic brain syndrome repairs to a functional state and the observable disorders disappear.

While declines in numerous interdependent factors can contribute to an acceleration of the biological aging process, normal functional reserves of the body are usually quite sufficient for nonstressful situations.[12] But since stress demands adaptation and adaptation demands energy, any stress experience calls for an unusual expenditure of energy and this is more costly to the older than to the younger person. The physical and physiological changes that follow stress may upset the equilibrium of the elderly person, straining the individual's biopsychological capacity to adapt to the situation or find effective ways to control it. This results in anxiety which is added to the stresses already involved. As stated by Savitsky and Sharkey:[15]

> The awareness of these changes, at conscious and unconscious levels, may carry connotations of deprivation and loss which can stir up anxieties related to the earliest periods of development. Chronic brain syndrome is of special importance; it acts as a source of stress and, in an especially significant way, undermines the individual's capacity to handle the resultant anxiety by lowering the threshold for regressive patterns of thought, feeling and action (p 4).

In addition to the stress brought about by metabolic insufficiency and decrements in the integrative functions of the brain, losses in visual and hearing acuity also accompany aging, contributing to social isolation, depression, paranoia, and confusion.[11,14,16] At any given age there is a large range of individual differences, and aging does not affect all the biological systems at the same rate or in the same manner. Indeed, data from longitudinal studies of individuals show that the decrements between the ages of 20 and 80 are very small in healthy individuals. But the practitioner must be aware that, in elderly suffering from health problems, the cycle of declining physiological strength and acuity, accompanied by feelings of insecurity, fear and anxiety, can lead to withdrawal from social participation. The resultant isolation in turn may lead to further depression, lack of activity and a decline in appetite that negatively affects adequate nutrition. The use of family members, friends, or caretakers to provide stimulation and social contacts should be explored vigorously. With their understanding, patience, and involvement, impaired elderly can usually be helped to function close to maximum potential.

Psychosocial stress and aging. At one time it was believed that role losses associated with work, children, and spouse triggered mental illness in the elderly. Subsequent research has suggested, however, that there is a difference between low morale and mental impairment. Lowenthal[17] found that social role loss can dampen morale and lower feelings of satisfaction, but actual mental illness is more likely triggered when the role loss is identified with conflicts over unattained life goals, previous guilt associations, and personality characteristics:

> Under these circumstances, such social losses are experienced as a threat to integrity and self-esteem, and therefore, a threat to psychic equilibrium. . . Sadness, malaise, or low morale result when these losses are experienced as events over which one has no control, but they are not perceived as a threat to the ego. We are suggesting that it is inner conflicts that threaten the ego's integrity and lead to psychic breakdown in old age. . .whereas social stresses or conflicts that can be envisaged as stemming from external social forces or norms do not threaten the ego's defenses (p 191).

Psychogenic factors by themselves probably do not cause mental illness any more than the presence of a germ causes disease. The psychological equilibrium of the host must be vulnerable to social and psychic stress just as the biological organism must be vulnerable to invading germs in order for pathology to result.

But role loss that also involves social isolation may be a dangerous combination for continued mental health. Clark and Anderson[18] who worked on the study of San Francisco aged feel that their data clearly implicate social isolation in the prevalence of mental problems. It is their position that good physical health and adequate income will not suffice to mitigate the risk of mental illness in the later years: "If an aged individual is bereft of social alliances, neither an adequate standard of living nor good physical health diminishes his risk of mental breakdown in later life" (p 142). These social alliances are seen as sources of social approval which are required for continued self-esteem.

The importance of social alliances takes on different dimensions for elderly men and women, probably in large part, because so many women are widowed.

In the elderly years as in the younger years, marriage seems to act as a buffer to mental illness.[8,19] Of those 65 and over, 73% of the men are married and only 17% widowed, whereas 56% of the women are widowed and only 36% married.[20] Elderly men are not only more likely to be married, but to view their wives as their confidants; whereas women who are widowed and socially isolated suffer from a high degree of social deprivation.

Lopata[21] who studied urban widows extensively concluded that the interdependence of middle-class husbands and wives makes the initial adjustment to widowhood very difficult for those women in comparison with lower-class women, whose marital role is traditionally house-bound, and distinctly separate from that of their husbands. But following bereavement the broader life experiences of the middle-class woman make it just that much easier for her to locate new resources, and take the initiative in reorganizing social contacts and activities. Often, however, the older woman is likely to be poor and low in education. She lacks social contacts and is very limited in the social experiences needed to forge new links to society. Her older relatives die, further eroding family resources. The resulting status loss as well as the diminution of social contacts exacerbates feelings of loneliness, uselessness, and low self-esteem. A renewed identity is not possible without new social experiences, but these experiences are specifically what such an elderly widow is unwilling and unable to undertake.

Coping. When Robinson Crusoe found himself stranded on a desert island with no visible means of escape, he suffered a terrible sense of hopelessness and contemplated suicide. Before ending his life, however, Crusoe sat down and constructed a double list: Reasons to Live and Reasons to Die. After studying the lists, he concluded that life would be the preferable choice. The Robinson Crusoe approach to coping offers an excellent model for assessing the personal and environmental strengths and weaknesses in one's life. Often elderly patients are not the only ones depressed and discouraged about their problems. Adult children frequently see in their elderly parents the declines and limitations they fear for themselves in the coming years. They focus on the decrements and risks to safety rather than on the relative balance of strengths and weaknesses.

Coping is an activity that is necessary for mental health because it is the exercise of options. Coping refers to activities that an individual engages in

that are intended to control the outcome of events perceived as physically or psychologically threatening. Some coping behaviors are active and concentrate on changing the situation itself; others are cognitive and focus on changing the meaning of the situation; and others are designed to permit avoidance of the situation.[22]

When individuals believe they lack the resources or the competence to control perceived threats, they experience stress. It is a negative emotion that occurs when demands exceed one's adjustive resources.[23,24] Situational crises, such as death of a loved one or entering a nursing home, provide common examples of stressful events which demand coping behaviors to facilitate adjustment. There are also coping behaviors in elderly that are dysfunctional. In their comparative study of mentally well and mentally ill elderly, Clark and Anderson[18] found that sharp differences existed in the way each group behaved. Ambition, competitiveness, and continued control were still the significant modes of behavior for the elderly mentally ill. The well elderly shifted from the highly competitive, acquisitive and self-advancing values of the larger society to a slower pace, to acceptance of irreversible change in themselves and in their situations, and to an emphasis on harmony and congeniality.

Practitioners can be especially supportive of patients who cope actively with their health problems through responsible choices of life style. Belloc and Breslow[25] studied 7,000 Californians

to relate health status and health practices. They examined seven heathful practices:

Get 7 to 8 hours sleep per night
Eat breakfast regularly
Don't eat between meals
Keep within a few pounds of ideal weight
Engage frequently in active sports or exercise
Drink moderately or not at all
Don't smoke.

They found that persons over 75 who followed all seven practices were as healthy as persons 30 to 40 years younger who followed fewer than three.

Healthcare practitioners are often in the best position to help families reach an objective assessment of the situation. The elderly themselves are usually in the best position to judge how much risk they can and are willing to tolerate. Maximizing safety to the point of erasing all risks may ease the minds of the adult children. But if it reduces the options of the elderly to a level that compromises their self-esteem and competence, the trade-off is dangerous to mental health.

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Problems and prospects in the treatment of dementia

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TWO DECADES AGO the confused elderly were regarded as hopelessly senile, and the cause of the malady was cerebral arteriosclerosis. Increasing attention and careful observations have radically reshaped our thinking on psychiatric illness in the elderly and on the symptom complex of dementia. The term dementia refers to a chronic, progressive, age-related impairment in cognitive function with onset in late middle life (before age 60—presenile type) or onset after age 60 (senile type). It is estimated that three million elderly Americans presently suffer from significant cognitive impairment.[1]

The paradigm of cerebral arteriosclerosis limiting blood supply and oxygen led to attempts to produce vasodilatation with various drugs, but no impact on the course of dementia was observed. Further, the failure to identify a specific alterable biological cause engendered pessimism among health professionals, resulting in diagnostic and therapeutic nihilism. Epidemiological research suggested that the prevalence of dementia increased with each decade of life,[2] thereby adding to pessimism. The conclusion reached was that "senility" was inevitable, caused progressive deterioration, was not etiologically diagnosable, not treatable, and that chronic brain syndrome could best be managed in a biomedical model which fostered institutionalization.

The term chronic brain syndrome came to be used as a rubric for all manner of psychiatric disability in the elderly. And further, the absence of a specific cure led to a retreat by the health professions from active involvement in the care of these unfortunate elderly patients.

More recent reconceptualization and research had lead to a rebuttal of these pessimistic assumptions and has led to more appropriate assessment of the dementing processes in the elderly.

Seltzer and Sherwin[3] demonstrated that all but three of 80 random Veterans Administration hospital patients given nonspecific organic brain syndrome diagnosis could be assigned to specific diagnostic categories. Wells[4] noted that up to 10 to 15 percent of the dementias were reversible if treated by appropriate medical or surgical procedures. An additional 25 to 30 percent of patients could be benefitted if thorough diagnostic and specific therapeutic measures were taken. It is now apparent that careful evaluation will reveal multiple causes for the behavioral changes in patients formerly lumped in the category of chronic organic brain syndrome.[5]

Arteriosclerosis, formerly thought to be the most common cause of dementia, now has been demonstrated to cause a minority of dementia cases, less than 20 percent. And further, that the mechanism for arteriosclerotic dementia is not impairment of blood flow to the brain, but in these cases is caused by multiple infarctions of brain substance with the loss of cognitive function proportional to the amount of loss of functioning brain tissue.

Hachinski[6] points out that the course of multi-infarct dementia has rather consistent features and that the following ought to suggest strong consideration of this diagnostic possibility: abrupt onset, stepwise deterioration, markedly fluctuating course, history of "strokes," history of sustained hypertension, presence of significant hypertension, and focal neurological signs.

After careful diagnostic studies are done and dementias due to a specific identifiable cause or multi-infarct disease of the brain have been excluded, there remains the largest unknown etiological group of the dementias now known as senile dementia, Alzheimer type or according to DSM III, primary degenerative dementia. At this time definitive diagnosis can only be made by brain biopsy or at autopsy.

The pitfalls in the treatment of the dementias not only include the failure to search for reversible and identifiable clinical entities but also dementia may be overdiagnosed in the troubled elderly person.

This difficulty was summarized in a recent paper by Garcia[7] on the overdiagnosis of dementia. A study of the diagnosis of dementia was carried out in a multidisciplinary clinic staffed by a neurologist, psychiatrist, internist, with additional services by psychology and social work departments. Of 100 patients referred to this clinic, it was determined that at least 26 were not demented, 15 suffered from a depression, seven had miscellaneous other neuropsychiatric disorders and four were normal. Garcia made note of three recurring diagnostic errors: (1) failure to recognize depression, especially in the presence of mild organic brain disease; (2) equating brain atrophy on computerized axial tomograms of the brain with clinical

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dementia; and (3) the failure to distinguish focal from global intellectual impairment.

Wells[8] made the sage observation that no single medical specialty has so far been willing to assume primary responsibility for the medical care of demented patients. Neurologists are often consulted to verify diagnosis but are generally not interested in providing primary long-term care. Internists and family physicians usually provide treatment for current medical problems in these patients but are not comfortable dealing with symptomatic and behavioral manifestations. Psychiatrists are often consulted only when behavioral problems become uncontrollable, and with the exception of a handful of geropsychiatrists, have usually been more involved in other psychiatric pursuits.

The absence of specific therapy to halt or even ameliorate the course of Alzheimer's disease had lead to a pervasive sense of nihilism in the medical profession. Of the pharmacologic agents used in the past, perhaps only Hydergine® still maintains some limited credibility in the opinion of some workers. In a recent review by Hicks[9] of 18 carefully controlled studies, he noted that 15 of the 18 studies suggested positive results. It should be noted that these positive results were present in only early or moderately advanced dementias and long-term therapy was needed to observe effects. Reisberg,[10] in reviewing pharmacologic treatments of cognitive decline in the aged, has suggested that of the nootropics, Piracetam (2-oxo-1-pyrrolidine acetamide) has shown much promise. This compound is a derivative of gamma amino butyric acid (GABA), a neurotransmitter. Its effects appear to be limited to the central nervous system with a total lack of peripheral effects. Some studies suggest positive effects in persons with mild to moderate dementia, but not those of severe dementia.

The discovery of deficiences of cholinergic enzymes in the brains of Alzheimer's patients raised the hope that supplying the precursors of acetylcholine might overcome the theorized decrease in acetylcholine synthesis.[10,11,12] So far there is no clear-cut dramatic effects in demented patients who received acetylcholine precursors such as lecithin and choline. More studies are in progress.

At this moment in time then, no specific pharmacologic therapy has proven to be consistently reliable in the treatment of cognitive decline of patients with primary degenerative dementia or Alzheimer's disease.

In addition to the pharmacologic approaches, other nonspecific measures that are important in the treatment of dementia are the assessment and the improvement in sensory impairments, particularly in hearing and vision; also, the prescribing of appropriate diet and exercise, which is sometimes neglected in this group. Metabolism of the elderly may affect the illumination of drugs, and toxicity can result from previously well-managed doses of various medications. In addition, specific drugs including barbiturates, diazepam, and other tranquilizers may be especially hazardous in the elderly person with mild confusion. It would be well for the physician to eliminate all nonessential medications because it has been shown that the most common cause of forgetfulness and confusion and disorientation in the aged is drug intoxication. In fact, many wise physicians, when confronted with a first episode of confusion in an elderly patient, have simply eliminated all drugs for a trial period with reintroduction of only essential medications.

It is at this point that many physicians feel the medical model has contributed all that it can. A comprehensive approach, however, would include a control of the resultant behavior of dementia and a consideration of family problems incurred in maintaining a confused elderly patient in the home and other environmental and economic problems beyond the scope of medicine. Ingelfinger,[13] former editor of the *New England Journal of Medicine,* expressed the opinion that medicine's ability has been oversold; and that although it has been very successful in crisis care, this very success has uncovered many chronic conditions for which medicine has little treatment to offer. He

stated, ". . .the physician has enough to do if he takes care of the crisis illnesses that do occur, and if he keeps up to date with the various scientific facts known about their nature and management. Hence, I would not consider the failure of the doctor to practice holistic medicine as substantive evidence of inferior medical practice."

Raskind[14] has suggested that the "secondary behavioral manifestations" of dementia are the most treatable aspects, particularly depression, agitation, night wandering, and the like. Psychotropic agents, carefully selected as to type and dosage by the geropsychiatrist may be extremely effective in control of paranoid states, confusion, agitation, sleep disturbances, depression, and other behavioral manifestations. The demented patient ought to be entitled to such treatment as it may improve his life and health and give ease and comfort to the family and/or caregivers.

It is therefore necessary to depart from the medical and behavioral models and focus on family, social, and environmental treatment modalities to provide optimum care. Since dementia in its advanced stages leads to a loss of ability of the demented person to care for him or herself, complex social problems occur. Families are often bewildered by the behavior of the patient. They are in need of education regarding the causes, expected outcomes, and resources available for their task of care. Structuring the environment, motivation therapy, reality orientation, are important for the demented patient. The family will need periodic respite to continue to maintain a demented individual in the home and greatly benefit from support groups. A family will also need periodic monitoring and counseling about the selection and the timing of institutionalization. The British, who spend half as much as the American healthcare system on the care of the elderly, have been able to provide a rich array of community-based services of visiting health personnel to provide care and support for demented patients and families in their own homes. This approach has lead to the maintenance of seven out of eight demented patients in the community in Great Britain. With rising healthcare costs, it would appear necessary that families bear a greater brunt of the burden of caring for demented elderly. Knowledgeable physician involvement is essential for a successful biopsychosocial approach to the treatment and care of the demented patient and his or her caregivers.

NEWS NOTE

Taking care of older veterans

Officials involved in the medical care of United States and Canadian veterans met recently to discuss future plans for taking care of patient populations that are growing older.

Veterans Administration chief Robert P Nimmo noted that both countries face an unprecedented health care demand posed by a virtual population explosion among aging veterans. The number of United States veterans over age 65 will nearly double in the next five years, he said.

Nimmo welcomed the Canadian initiative in studying the US state-of-the-art in geriatrics and gerontology. He promised full cooperation in "exploring common concerns" the two countries share in attempting to adjust veterans programs to meet special needs of older patients.

During these discussions of aging veteran populations, the following facts were noted as compelling reasons for increased attention to planning for extended care for former servicemen and women:

- During the past five years, the number of US veterans aged 55 to 74 has increased 17 percent; and it is now estimated that by 1990, two of every three American males over age 65 will be veterans.
- By the year 2000, the current population of veterans over age 65 will have increased from just over three million to nearly eight million.
- Studies of healthcare usage among patients from different age groups show patients in the over 65 bracket need more physician time, more hospital admissions, and longer hospital stays than younger individuals.

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Management of infections in the elderly

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ABSTRACT. *Elderly persons appear to have an increased susceptibility to certain types of infection and seem to be less tolerant of their adverse effects. Symptoms and signs of infection in elderly patients may be altered, causing delays in diagnosis and treatment that may enhance the severity of the illness. Finally, antibiotic therapy may be associated with an increased complication rate in the elderly, making treatment of their infections more difficult.*

INFECTIONS ARE a major cause of morbidity and mortality in the elderly. In this group of patients infections can be either primary in nature or secondary to other medical problems whose incidence also increases with age. Also, complications of infections and of their treatment appear to be increased in this group, owing either to reduced effectiveness of host defense mechanisms or to other associated medical conditions. It is important to realize that advanced age does not predispose to all types of infection equally; some appear to be more frequent than others. The purpose of this review is to consider which infections are most common in this group, how their presentation may be altered by advanced age, and why the patient's age may influence antibiotic therapy.

Types of infection in the elderly. Whereas the elderly appear to have an increased incidence of infections overall, certain types may actually be less common in this group. In particular, those caused by *Hemophilus influenzae* and *Neisseria meningitiditis* are less frequent than in younger individuals, presumably because of preexisting protective antibody.[1] Similarly, although the incidence of herpes zoster increases directly with age,[2] this relationship does not appear to hold for other viral infections. In particular, the incidence of viral pneumonia is low in elderly individuals.

Some bacteria, particularly *Streptococcus pneumoniae* and certain Gram-negative rods, do cause an increased number of infections in the elderly. These bacteria are probably the most important infectious causes of morbidity and mortality in this group. In particular, pneumonias produced by *Streptococcus pneumoniae* are a major cause of death in the aged. However, those caused by Gram-negative bacteria are also more common in the elderly and have a high mortality rate.[3] Associated medical conditions such as chronic obstructive lung disease or neurologic abnormalities predisposing to aspiration may be a cause of pneumonia in this group. Influenza is frequently complicated by bacterial pneumonia, especially in the aged.

Bacterial infections related to local factors such as urinary tract infections and infected skin ulcers are also common in the elderly. Urinary tract infections may be related to prostatic disease in men and weakening of the pelvic floor in women, although indwelling catheters, neurogenic bladder, or calculi can also be causative here. Asymptomatic bacteriuria occurs with greatest frequency in older individuals; its significance is unclear, although one study has demonstrated an increased mortality rate in those elderly individuals with this condition.[4] Local skin infections are most frequently produced by ischemia due to vascular insufficiency or by decubitus ulcers caused by neurologic diseases such as cerebrovascular accidents. The bacteria involved in these infections include *Staphylococcus aureus,* Gram-negative enteric bacteria, and anaerobes.

Bacteremia appears to be more frequent in the elderly because the infections causing it, such as urinary tract infection and pneumonia, are also more frequent. Bacterial endocarditis is also an important cause of bacteremia in the elderly. This type of infection more often follows surgery in this group of patients and has been related to sclerotic changes in the aortic valve.[5] As expected, the organisms causing bacteremia in the elderly are those involved in the associated infections: *Streptococcus pneumoniae,* the streptococci causing endocarditis, Gram-negative bacilli, *Staphylococcus aureus,* and occasionally anaerobic bacteria.

Certain other infections are also more common in the elderly. One example is tuberculosis. Reactivation of latent infection is the most common mode of developing this condition in adults. Since tuberculosis is less common today, more elderly than young persons have been exposed to it and are at risk for reactivation. However, reactivation may also occur more frequently in this group because of an age-related depression of cell-mediated immunity or the development of other associated conditions that might result in reactivation, such as cancer, diabetes mellitus, or the like. Some studies have demonstrated that superficial fungal infections are more common in the elderly

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Reduced vigor of cell-mediated immunity in these patients has been blamed for this increased incidence as well as the frequently asymptomatic nature of the infections.[6]

Relationship of age to the complications of infections. Complications of infections appear to be increased in the elderly. Mortality rates are higher in these individuals for several types of bacterial infections, such as endocarditis, meningitis, and pneumonia, as well as bacteremia from any source.[1] Pneumonia is more likely to have a delayed resolution in the elderly,[7] and respiratory failure from pneumonia is more common in this group because of the higher incidence of associated respiratory problems such as chronic obstructive lung disease and congestive heart failure. Herpes zoster is followed more frequently by post-herpetic neuralgia in elderly than young patients.[8] Elderly persons also appear to handle tuberculosis poorly with an increased incidence of cavitary disease and extrapulmonary dissemination.[7] Associated conditions which interfere directly with host defense mechanisms such as cancer and diabetes mellitus may play a role in increasing the complication rate of infections in the elderly.

Atypical presentation of infections in the elderly. The signs and symptoms of infections may be altered in elderly individuals, often causing delays in diagnosis. Fever frequently is reduced or absent during significant infections in this group. It has been demonstrated experimentally that older animals are less sensitive to endogenous pyrogen than are young animals.[9] The presenting symptoms and signs of infection may therefore be different in the elderly; mental changes such as confusion, delirium, or agitation frequently occur first, although infection may also present as hypotension, oliguria, acidosis, or tachypnea in these individuals. Signs pointing to a particular site of infection may frequently be lacking: for example, pneumonia may be associated with minimal cough or sputum production in the elderly. The onset of tuberculosis may be particularly insidious. There is also a higher incidence of completely asymptomatic infections such as asymptomatic bacteriuria and noninflammatory superficial mycoses.

Treatment of infections in the elderly. As discussed above, elderly persons appear to be more susceptible to severe bacterial infections than are younger individuals. They also have an increased rate of complications from these infections. Because the signs and symptoms are frequently altered, the diagnosis of infection is often delayed, adding to the morbidity and mortality of this type of illness. This situation is unfortunate, because effective antimicrobial therapy is almost always available for the bacterial pathogens most frequently causing disease in this group of individuals. Therefore, it is of utmost importance to consider the possibility of bacterial infection when presented with an elderly patient having vague symptoms and an uncertain diagnosis.

The evaluation of an elderly patient suspected of having an infection is similar to that in a younger patient, although it should be realized that localizing signs may be less prominent. If no local site of infection is found by the initial examination of an elderly patient in whom bacterial infection is suspected, consideration should be given to the initiation of broad spectrum antibiotic therapy pending the results of cultures.

Although it often seems prudent to begin antibiotic therapy on an empiric basis in elderly individuals because of their increased susceptibility to and complication rates from bacterial infections, one should bear in mind that this group may also suffer from an increased number of complications from antibiotic therapy itself. The large fluid and salt loads given with certain antibiotics (particularly the penicillins) may aggravate congestive heart failure in these individuals. Also, because of their increased susceptibility to bacterial infections in general, suprainfections with Gram-negatives may result more frequently from antibiotic therapy in this group. Because of the decreased glomerular filtration rate in the aged, the toxicity of antibiotics cleared through the kidney such as aminoglycosides may be increased. Finally, the hepatic toxicity of isoniazid is increased with increasing age. Therefore, although it may be appropriate to initiate antibiotic therapy in elderly individuals on the basis of less solid evidence for bacterial infection than in younger individuals, one should be certain to monitor this therapy carefully to avoid unnecessary complications.

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Evaluation and treatment of hypertension in the elderly

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ABSTRACT. *Treatment of hypertension has become accepted in the young and middle-aged after years of scientific research and clinical investigation. This trend may be beginning to pay big dividends. This paper discusses the changes in blood pressure with age, effect of blood pressure on cardiovascular morbidity and mortality in the elderly, a clinical approach to patients, and speculates on treatment.*

DEATH CERTIFICATE data suggest that cardiovascular disease is the leading cause of mortality in the aged and that stroke ranks third. As important as these facts are, perhaps more important is the incalculable suffering and diminution in quality of life associated with congestive heart failure, renal disease, and stroke, all of which are common in the elderly population whom clinicians see daily. Hypertension (defined as systolic exceeding 160 mmHg and diastolic exceeding 90 mmHg or as isolated systolic hypertension if systolic exceeds 160 mmHg with diastolic less than 90 mmHg) is estimated to be present in 40% of whites and in more than 50% of blacks who are elderly.[1] Elderly are arbitrarily defined as persons aged 65 and over. The exceedingly high prevalence of this condition raises questions as to what, if anything, should be done when the clinician encounters someone over age 65 with high blood pressure. In addition, if detection and treatment of hypertension impacts upon cardiovascular morbidity and mortality, the elderly become a group with a lot at stake in terms of blood pressure management.

Blood pressure changes with age. Increasing age is associated with increased rigidity of the aorta and peripheral arteries due to loss of elastic fibers in the media of vessels, increase in the amount of collagen in the media, calcium deposition in the media, and atheroma formation in the intima. The precapillary arterioles (responsible for most of the resistance in the circulation) may change with age *per se,* although the situation is not as clear as for the larger vessels. Renal function (as measured by glomerular filtration rate, concentrating ability, or tubular function) is also known to decline with age, although the effects of renin and aldosterone producing blood pressure alterations with increasing age are uncertain.[2] The sympathetic nervous system also undergoes changes with age (*ie,* higher plasma norepinephrine for a given stress, decline in beta-receptor number), but again, the exact role these autonomic changes play in blood pressure maintenance with age is unknown.

Measurement of blood pressure in longitudinal and cross-sectional studies[3] suggests that increasing age is associated with a steady rise in systolic blood pressure. Diastolic pressure rises in young adulthood and then plateaus in the late 50s. The degree of rise in systolic pressure is greater than diastolic over the same periods of time. However, most experts[3,4] agree that blood pressure rise occurs within the range of "normal" for adults so that the systolic pressure remains in the 150-160 mmHg range and diastolic pressure 90-95 mmHg range, maximum.

The above information still does not answer the question as to what is "normal." Libow[5] has pointed out that two approaches are possible trying to clarify this issue. One approach would be to take large groups of elderly, calculate means for systolic and diastolic pressures, and then assume that two standard deviations from the mean is abnormal. This might be statistically correct, if blood pressure measurements are distributed according to a bell-shaped curve. However, this approach is flawed in that it does not define what risk, if any, a given blood pressure has for an individual. The approach taken in the Framingham study,[3] however, does give us a clear picture of this problem. In this study it was shown that hypertension is a distinct threat to life in old as well as young subjects. In addition, absolute risk for cardiovascular disease conveyed by hypertension *increased* with age. This data negates the axiom about older people needing a higher blood pressure for survival or that hypertension is somehow protective to the elderly patient. Also, it should be reiterated that *both* diastolic and, just as importantly, systolic

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blood pressure carry risk in the elderly for death and cardiovascular events in both sexes.

Is Treatment of Any Benefit?. The argument has been made that hypertension *per se* may only be a marker for higher mortality or cardiovascular morbidity and altering it will not have any effect on a given patient's clinical course. To settle this question one needs to design a randomized, controlled, double-blind, prospective study which will document blood pressure control in treated groups and then correlate this effect with improved mortality and morbidity over controls. Studies need to be carried out in large enough populations to detect effects and continued long enough so that effects of therapy may be measured. Such studies have been undertaken in young adults and middle-aged people and have established benefit of treating hypertension.[6,7] Unfortunately, things are not so clear as regards the elderly. Given the high prevalence of blood pressure abnormalities in this population, one would have presumed that the aged would have been the prime group studied in large trials. Koch-Weser[8] points out that in 41 drug trials between 1972 and 1976, of 1000 people involved, only *seven* were over 69 years of age! Despite this fact, there is limited information available regarding the effect of treatment of blood pressure in elderly hypertensives.[6,7] Space does not allow a thorough analysis of all the data, and the reader is referred to some recent review articles[9,10,11] for the pertinent details. The Joint National Committee on Detection, Evaluation and Treatment of High Blood Pressure[12] states that based on the findings of the Hypertension Detection and Follow-up Program elderly patients with combined systolic-diastolic hypertension will benefit from antihypertensive therapy. Another smaller, but more recent study[13] confirms these findings. In addition, what all the studies find is that therapy is not harmful to the elderly subjects under study. Anecdotes and case reports[14] can be readily found to support the theories that treatment of blood pressure in the aged is dangerous. However, generalizations suggesting that treated populations of elderly are adversely affected from treatment more than they benefit can not be made from current studies. Furthermore, it might be argued that some of the adverse effects noted by clinicians when elderly patients are treated are due to inappropriate drug dosages and overaggressive management.

One further point needs to be made regarding isolated systolic hypertension. For all intents and purposes, this is a condition which is predominantly seen in the elderly. Once the diagnosis is secure (one must rule out secondary causes such as aortic insufficiency or hyperdynamic circulation from fever, anemia, sympathetic release, hyperthyrodism, Paget's disease and arteriovenous fistula), the decision whether or not to treat still remains in question. Although studies are underway to look at this problem, data are not yet available for interpretation. My own bias is that patients with target organ damage, especially evidence of left ventricular work or heart failure or large vessel disease as manifested by stroke or peripheral vascular disease, require cautious treatment with appropriate patient monitoring. The goal of therapy is ideally a systolic pressure of 140-160 mmHg. Again, this is arbitrary; it remains to be seen whether drug trial data will support this approach. Stroke, myocardial infarction, congestive heart failure, and peripheral vascular disease with gangrene and amputation are illnessess that geriatricians and healthcare providers to the elderly see in large numbers and which profoundly affect the quality of life available to the elderly. Any measure which can help to safely decrease the incidence of these illnesses should be employed regardless of the person's age.

Approach to the patient. The clinical evaluation of a patient with hypertension is quite familiar to the readers of this Journal. A few comments need to be made about the elderly patient.

History is helpful in assessing target organ damage (*eg,* angina, transient ischemic attack or intermittent claudication). Elderly people desire to remain independent and at times may deny illness or not report symptoms because they feel symptoms merely represent normal aging phenomena. The practitioner must be aware of a tendency by the elderly to under-report illness and at times, directed questioning is indicated to define whether a problem is present. Drug history is also important. If the person sees more than one physician, he/she may be using agents prescribed by someone else that may lead to elevated blood pressure readings (*eg,* some nonsteroidal anti-inflammatory agents used to treat arthritis, steroids, or cold preparations containing sympathomimetic agents). I advise my elderly patients to bring *all* their medication to the office, including over-the-counter drugs. The Visiting Nurse is a good resource in this regard also, since she can take inventory in the medicine cabinet and help decipher what medications the patient actually uses.

Physical examination should be tailored to the elderly person. Nondistensible vessels and a less sensitive baroreceptor mechanism combine to not dampen blood pressure as effectively as in the young. As a result, lability of blood pressure (especially systolic) may be more frequent in the aged and the need for three independent readings is important in this population, especially for mild cases or isolated systolic hypertension.

Blood pressure should be taken in both arms since arteriosclerotic narrowing of the subclavian can occur in the aged (subclavian steal). The high-

er reading should be used as a gauge for treatment. Orthostatic blood pressure should routinely be performed. Caird[15] has reported that close to one-fourth of healthy elderly may have a significant drop in blood pressure upon arising from the recumbent position. Certainly a baseline is necessary before employing drugs that may worsen orthostasis. A final comment about measuring blood pressure in the elderly must be mentioned. Spence[16] has described an entity known as pseudohypertension. The sphygmomanometer has been felt to be a good reflection of intra-arterial blood pressure. However, in 24 elderly hypertensive patients Spence found 12 who had a falsely elevated cuff reading when compared to intra-arterial values. The cuff values averaged 30 mmHg higher than the true readings. Exactly what percentage of all elderly hypertensive patients have pseudohypertension is unknown. Individuals with hypertension, little evidence of target organ damage and who seem to be very sensitive to even small doses of antihypertensive agents, may fall into this category. More research on this subject is needed and perhaps better methods of measuring blood pressure in the elderly should be developed.

The remainder of the physical examination concentrates on careful evaluation of target organs (eyes, heart, large vessels, central nervous system) and looking for diseases known to cause blood pressure elevations (*eg,* renal artery stenosis, Cushing's disease, and the like).

The laboratory evaluation should be kept as simple as possible. In most instances the approach is similar to the young. Renal function should be assessed with blood urea nitrogen, serum creatinine, and urinalysis. Electrolytes are obtained looking for abnormalities that might present with aberration of these values (*eg,* licorise ingestion leading to hypokalemia or primary/secondary hyperaldosteronism yielding the same). Glucose is measured since diabetes is common in elderly hypertensive patients[10] and agents used to treat hypertension may affect serum glucose. The same holds true for uric acid. An electrocardiogram has an important role in measuring left ventricular hypertrophy and is an indicator of previous myocardial infarction. The "typical" symptoms for a myocardial infarction are manifest in only a minority of cases in the aged[17] reinforcing the concept that common illnesses can and do present atypically in geriatric patients. Whether more invasive laboratory evaluation is required will vary on a case-by-case basis. Certainly, tumors of the adrenal gland should be pursued. Renal artery stenosis, a curable cause of hypertension in the young, may result in hypertension in the elderly. However, surgical results are not comparable to the young, and medical management is employed unless secondary aldosteronism with its concomitant hypokalemia limits therapy or the blood pressure is severe and refractory to treatment. Laragh[2] advocates renin profiling as part of the evaluation in this population, with treatment varying depending upon the renin level. He estimates that up to one-third of elderly hypertensive patients have a high renin and should receive a beta-blocker as first line therapy. Most centers and investigators are not as aggressive in this regard.

Therapy. Once a decision has been reached to treat the patient, a therapeutic regimen needs to be prescribed. Nonpharmacologic approaches include sodium restriction and weight loss. As in younger populations, efforts to achieve these are not always successful. The elderly, in addition, have age related changes in olfactory and gustatory sensation potentially making sodium restriction quite difficult. Referral to a dietician who is knowledgeable about the elderly and their special nutritional needs[18] can optimize diet approach to therapy.

Once medical therapy is decided upon, following the stepped care approach is recommended.[1] A few comments should be made as regards the different agents available for treatment. The drug prescribing principles outlined in another accompanying paper (Lund and Duthie) should be adhered to. When using diuretics recall that potent diuretics may promote urinary incontinence and this will jeopardize compliance with a regimen and make a patient miserable. Also with these agents, hypokalemia can be a problem especially for individuals whose dietary intake of potassium is questionable or who lose potassium in their stool by cathartic abuse. Potassium supplements are prescribed on a case-by-case basis and are never routine. Use of a supplement in the presence of a potassium-sparing diuretic is dangerous in the elderly person who has a diminished glomerular filtration rate simply as a result of aging (not to mention potential further renal compro-

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mise from nephrosclerosis of hypertension or other renal disease.)

Step two agents also may require some modification. Sexual function[18] remains into late life and should be inquired about when starting therapy and during therapy. Beta-blockers can be used in the elderly even if there is a slower resting heart rate than seen in younger individuals; however, symptomatic bradycardia will interdict their use. Any agent which is associated with depression should be used cautiously since clinical depression is common in the elderly and can have disastrous consequences (*eg,* pseudodementia, suicide). Finally, vasodilators, especially hydralazine, may not give the usual reflex tachycardia seen in younger hypertensive patients since with age there is a diminished baroreceptor response.

In general, experts agree that treatment regimens should be kept simple and that low doses of all agents be initially employed since this group of people tends to be sensitive to the effects of these drugs and their side-effects. A sound knowledge of the drug, its side-effects, and any pharmacokinetic-pharmacodynamic differences in the aged combined with a cautious approach should result in a successful regimen which is safe.

Summary. Hypertension is a major health problem in the geriatric population. With ever-increasing numbers of elderly presenting to physicians for therapy, some knowledge of the aging process, its effect on blood pressure, and the disease hypertension is required. Clinical studies are not yet adequate to answer all the questions regarding diagnosis and treatment of the elderly person with high blood pressure. Once therapy is undertaken, the special aspects of altered physiology in the aged patient and geriatric pharmacology combine to make successful and safe therapy challenging but possible.

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Management of the elderly diabetic patient

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ELDERLY PATIENTS comprise about one-third of the total diabetic population. Data suggest that glucose tolerance is impaired with advancing age, which may contribute to an increased prevalence of non-insulin-dependent diabetes in the older individual. The primary cause of this glucose intolerance appears to be peripheral tissue insensitivity to insulin.[1] Lower amounts of carbohydrates in the diet, physical inactivity, and a higher ratio of adiposity to lean body mass with age could contribute to insulin resistance. In addition, age itself has been implicated as the cause of tissue unresponsiveness to insulin.[1]

Diagnostic criteria: Until carbohydrate intolerance associated with aging is shown to increase the risk of cardiovascular morbidity and mortality,

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it seems prudent to age adjust the standards for the glucose tolerance test in the elderly. A reasonable and conservative criterion for diagnosis of diabetes in the aged is at least two fasting plasma glucose levels over 140 mg/dl or 2-hour postprandial plasma glucose of more than 230 mg/dl.

CLINICAL CONSIDERATIONS. As the renal threshold for glucose increases with age, glycosuria and its associated symptoms of polyuria and polydypsia may be absent. Diabetes in the elderly is often asymptomatic and is usually detected by routine blood tests or oral glucose tolerance tests. The majority of these patients are noninsulin-dependent and are not prone to diabetic ketoacidosis. Hyperosmolar nonketotic coma, although rare, is almost exclusively seen in the older population. The common long-term complications in individuals who develop diabetes late in life are atherosclerotic cardiovascular disease, neuropathy, and cataracts. Diabetic retinopathy and nephropathy are less common.

GOALS OF THERAPY. Until recently, there has been a philosophy that as long as symptoms of hyperglycemia are controlled, the treatment of diabetes is adequate in older patients. Recent data suggest that maintaining normoglycemia will not only decrease long-term complications of diabetes but also will improve general well-being regardless of age. Nonspecific symptoms of memory loss, disorientation, and gait disturbances may improve with good control of diabetes.

When testing an elderly diabetic, the following specific facts need to be given priority:

1. Diet and exercise should be given priority, especially when associated with obesity.
2. Hypoglycemia due to oral hypoglycemic agents or insulin should be avoided or minimized.
3. Foot care must not be neglected because of a tendency for infections and gangrene.
4. A multidisciplinary team approach utilizing health professionals and a family member may be necessary for successful management.

TREATMENT. ***Diet:*** For most patients, the dietary goal is to achieve weight reduction and to maintain ideal body weight. Regularity of the caloric intake is necessary if the patient requires insulin or oral hypoglycemic agents. Total daily caloric range is from 1000 to 1800 calories depending upon sex, physical activity, age, and physiologic state. Carbohydrate intake should be generous, comprising 50% to 60% of the calories; 15% should be given as protein and 30% to 35% as fat. A decrease in the saturated fat with a proportional increase in unsaturated fat is advised. Recently, a high fiber diet has been advocated to improve glucose tolerance. This diet restricts caloric consumption by increasing satiety; moreover, the lax-

ative effect of a high fiber diet is helpful in the older patient. A good dietary guide for the professional can be found in the "Exchange Lists for Meal Planning" published by the American Diabetes Association and the American Dietetic Association.[2]

Exercise: A moderate degree of regular exercise should be encouraged. Exercise will lower body weight and increase glucose utilization by the peripheral tissues. Presumably, it will lessen the risks for heart disease by improving the lipid profile and cardiovascular function. Exercise improves muscle tone, appetite, and promotes a sense of well-being. Walking two to three miles a day is an adequate form of exercise. Weight loss and exercise may be all that is necessary in the majority of the elderly diabetic subjects.

Oral hypoglycemic agents: In patients with moderate hyperglycemia, if diet and exercise cannot lower fasting plasma glucose levels below 150 mg/dl, oral agents may be added to the regimen. There has been a controversy regarding the use of sulfonylureas[3] following the publication of the University Group Diabetes Program study. Evidence in the study implicating these agents as the cause of increased cardiovascular mortality is debatable and some feel it to be not well-founded. There is a role for these drugs in older diabetics; however, the controversy makes it imperative to give greater emphasis on the dietary management and more appropriate selection of patients for sulfonylurea therapy.[4] As many of the elderly diabetics are on multiple drugs, it is important to know their interaction with oral hypoglycemic agents.

The dosages of commonly used sulfonylureas and their duration of action are listed in Table 1. Chlorpropamide has a long half-life in circulation and is given as a single dose each morning. The other three agents should be given once, twice, or three times daily as necessary to maintain normoglycemia. There is a tendency for hypoglycemia if breakfast is delayed or in the absence of adequate caloric intake, especially with chlorpropamide.

Table 1—*Commonly used sulfonylureas*

Generic name	*Trade name*	*Daily dose range (mg)*	*Tablet size (mg)*	*Duration of action (hr)*	*Doses per day*
Tolbutamide	Orinase®	500-3000	500	6-12	2-3
Tolazamide	Tolinase®	100-750	100, 250, 500	12-24	1-2
Acetohexamide	Dymelor®	250-1500	250, 500	12-24	1-2
Chlorpropamide	Diabenese®	100-500	100, 250	32-72	1

Due to the long half-life and tendency to induce water intoxication, chlorpropamide may not be the drug of choice for the elderly diabetic patient. Tolazamide can be given once a day and has a mild diuretic effect, making this a useful oral hypoglycemic agent for the elderly.

Insulin Therapy: The indications for insulin administration in the older diabetic are the same as for younger individuals. Insulin therapy is necessary in patients with significant hyperglycemia who are at or below ideal body weight and in patients with a history of diabetic ketoacidosis or nonketotic hyperosmolar coma.

With insulin requirements of less than 30 units per day, one dose of intermediate acting (NPH or Lente) insulin is usually adequate. Approximate initial dose is 10 to 15 units daily with a gradual increment of 2 to 3 units every two to four days to attain optimal control. Patients who are ketosis prone or with unstable diabetes may require a mixture of intermediate acting insulin and regular insulin given before breakfast and before supper.[5] Errors in insulin administration are common in the elderly and must be watched for with the help of a family member. The timing and caloric content of the meals should be consistent on a day-to-day basis. The addition of supplementary snacks prior to physical activity should be advised. Glucagon injections should be made available to family members to treat severe hypoglycemia if needed.

A double voided urine before each meal should be tested for sugar and acetone in insulin requiring diabetics. If the renal threshold for glucose is high, however, a one- to two-hour postprandial urine sugar should be tested as an alternative. The presence of glycosuria in postprandial urine specimens in these patients can serve as a warning sign that diabetic control is inadequate. Availability of glycosylated hemoglobin assay allows the physician to assess the average diabetic control for the previous four to six weeks and is a useful tool in the management of insulin-dependent diabetics. Either fasting or postprandial blood can be drawn to estimate glycosylated hemoglobins.

Foot care: There is a higher incidence of foot infections and gangrene in the elderly diabetic due to the presence of atherosclerotic vascular disease and neuropathy. It has to be emphasized that preserving ambulation is of critical importance in the elderly population. Loss of the ability to ambulate can jeopardize independent living and result in admission to a long-term facility. A podiatrist should see the elderly diabetic on a regular basis to ensure good foot and nail care and provide guidance in wearing proper shoes.

SUMMARY. Elderly diabetics comprise a significant portion of the total diabetic population, and their management differs in many respects from that of younger individuals. A multidisciplinary team involving the physician, nurse, dietitian, podiatrist, and a family member should set up a mutually agreeable goal for the treatment with minimal changes in living pattern and dietary habits.

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Diagnosis and management of thyroid hormone problems in the elderly

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FOR YEARS GERONTOLOGISTS have been interested in a possible relationship between thyroid hormone and the aging process. Numerous clinical similarities between stereotyped senescence and hypothyroidism have been noted including a decline in basal metabolic rate, changes in skin and hair, cardiomegaly, constipation, decline in basal body temperature, and altered mental status. Despite recent advances in research technology, many unanswered questions still remain regarding this relationship.

Age-related changes in thyroid hormone economy. As a person ages, certain anatomical changes in the thyroid gland may occur. Gland atrophy and fibrosis may result in a decrease in total gland weight and the development of nodularity, both microscopic as well as macroscopic. Follicular size and colloid decrease and interfollicular connective tissue increase. Although the etiology for these changes is not known, the autoimmune system has been implicated. It is of great interest that both antithyroglobulin and antimicrosomal antibody titers increase with age. By the eighth decade, nearly 20% of persons will have elevated serum titers, slightly higher in women.

There remains considerable controversy regarding whether thyroid function becomes abnormal with increasing age. Despite a decrease in daily iodide turnover with increasing age, the 24-hour uptake of radioactive iodine by the thyroid remains constant throughout life.[1,2] This implies less absolute thyroid iodine accumulation and a diminished rate of hormone formation. Serum concentrations of free thyroxine (T_4) and thyroxine-binding globulin remain unchanged although not all studies are in agreement.[3,4,5,6] Kinetic studies of peripheral T_4 metabolism in males indicate a decreased metabolic clearance rate with advancing age such that by the ninth decade the metabolic clearance rate may be half that of younger men.[6] Interestingly enough, studies have failed to show this age-related decline in women.

There is presently general agreement that triiodothyronine (T_3) is the major active thyroid hormone involved with peripheral metabolism. Approximately 80% of circulating T_3 comes not from the thyroid gland itself, but rather is derived from the peripheral monodeiodination of T_4. Controversy remains regarding the levels of circulating T_3 in clinically euthyroid elderly individuals. Although most studies suggest a minor decline, this finding is not universal.[3] Since serum T_3 concentrations appear to decrease in patients with illness or nutritional deficiency despite the preservation of clinical euthyroidism (Euthyroid Sick Syndrome), some feel that the finding of an age-related decline in serum T_3 results more from age-related disability than age itself. Animal studies have shown a preservation of peripheral tissue conversion of T_4 to T_3 with increasing age.[7] Population selection is key in studies defining the effect of age on thyroid hormone economy and interpretation of data must take this selection into account.

Hyperthyroidism in the elderly. Between 10% and 17% of all hyperthyroid patients are 60 years of age or older. Although Graves' disease (diffuse toxic goiter) must be considered, this entity usually begins in the second, third, and fourth decades of life. In the elderly, hyperthyroidism is most likely due to a toxic nodular goiter. Despite this, approximately 20% of elderly patients with hyperthyroidism fail to have either enlarged or palpable thyroid glands. In approaching the elderly subject with suspected hyperthyroidism, caution is advised to not misinterpret the lack of classic symptoms as being noncompatible with the diagnosis. Typical eye findings associated with hyperthyroidism occur less frequently in the elderly. Often the elderly hyperthyroid patient manifests only one predominant symptom referrable to a single organ system, the most commonly affected being the cardiovascular system. Underlying cardiovascular disease combined with excessive thyroid hormone increases cardiac demand and exacerbates cardiac symptomatology. Palpitations and congestive heart failure are seen in approximately two-thirds of cases, and angina in about 20%. It is important to remember that excess thyroid hormone can lead to decompensation of the cardiovascular system whether underlying heart disease is present. Atrial fibrillation has been described to occur in almost half of thyrotoxic elderly patients; moreover, among elderly patients with unexplained atrial fibrillation, approximately 10% will turn up to have thyrotoxicosis. In those with atrial fibrillation, apical rates are notably slower in the elderly as compared to younger thyrotoxic individuals. In addition, there is less likelihood

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of a conversion back to sinus rhythm despite return to euthyroidism. The clinician should be particularly suspect of hyperthyroidism in elderly subjects who present with tachycardias or congestive heart failure, especially when therapeutic attempts are unsuccessful.

Weight loss is a frequent accompaniment of thyrotoxicosis in the elderly, occurring in over half of patients. This is usually associated with anorexia, in sharp contrast to the increased appetite that is more commonly found in younger thyrotoxic subjects. Diarrhea is less commonly seen in the elderly patient who is thyrotoxic, although the astute clinician may note an improvement in a preexisting constipation. Over two-thirds of thyrotoxic elderly complain of heat intolerance. A fine tremor is often disregarded in the elderly, although if present, may aid in diagnosis.

Besides the paucity of symptoms that so often accompany thyrotoxicosis in the elderly, some elderly present in a manner which has been referred to as apathetic hyperthyroidism.[8] The patient appears depressed, unanimated, and withdrawn. Often psychiatric disorders or malignancies are entertained. Specifically, this entity describes elderly individuals with placid, apathetic facies; small goiter; lethargy, depression or indifference; lack of usual ocular signs; substantial muscle weakness or wasting; weight loss; and cardiac dysfunction with or without atrial fibrillation. Thyroid function studies are abnormal, although the degree is quite variable. Although no definite etiology for this lack of classic symptomatology has been found to date, recent findings of age-related changes in autonomic or thyroid hormone receptors or Na^+-K^+ ATPase response to thyroid hormone[9] may be implicated.

In diagnosing the elderly patient as thyrotoxic, T_4 and T_3RU measurements are useful. Increasing-age should not in itself be implicated for abnormal values. If clinical suspicion is high, and T_4 and T_3RU are normal, a T_3 by RIA is necessary before a diagnosis of thyroxicosis can be dismissed. Although some argue that a high normal value of T_3 by RIA may very well suggest hyperthyroidism in the elderly, this remains controversial. A high serum T_3 by RIA, however, confirms the diagnosis of T_3 thyrotoxicosis, more commonly observed in elderly subjects. In this latter entity, T_3 formation by the thyroid gland selectively rises, leaving serum T_4 values either low or normal. In a rare patient, serum thyroid hormone rises only periodically making the laboratory diagnosis difficult and frustrating. In difficult diagnostic cases, a flat response of TSH to TRH administration, suggesting an autonomously functioning thyroid gland or nodule, can be used to confirm the diagnosis of thyrotoxicosis. In interpreting this latter test, however, caution must be advised in the aged, as age itself may blunt the TRH response; a "flat" and not blunted response must be elicited prior to confirmation.

Radioactive iodine therapy remains the treatment of choice for most cases of hyperthyroidism in the elderly. Caution must be advised against treating severely thyrotoxic elderly subjects prior to inducing clinical euthyroidism with medication or initiating adrenergic blockade. Although rarely seen, thyroid storm resulting from radiation-induced thyroiditis in the elderly thyrotoxic patient should be avoided at all cost.

Hypothyroidism. Major causes of hypothyroidism in the elderly include autoimmune atrophy, Hashimoto's thyroiditis, destruction by therapeutic radioactive iodine or surgery, and an inherited enzymatic defect not previously detected. Although clinical manifestations of hypothyroidism do not vary with age, diagnosis is often delayed due to clinical similarities between senescence and hypothyroidism. Only by first considering the diagnosis can one order the appropriate tests and then initiate treatment. Some geriatricians advocate yearly thyroid function screening for the elderly because of this common diagnostic clinical dilemma. Sawin, et al[10] recently reported findings on the thyroid status of 344 relatively healthy and clinically euthyroid people over 60 years of age. Twenty-two or 5.9% had elevated serum TSH levels. Of this group, one also had low values of T_4 and free T_4 index; however, only one had a low serum T_3 level, reflecting the ability of the thyroid gland to preserve the more metabolically active thyroid hormone despite a recognition by the pituitary gland that the thyroid gland is failing and serum T_4 levels can no longer be maintained as normal. Another 14% of the 344 subjects had what was considered to be slightly elevated serum TSH values; *ie,* $>5>10\mu$U/m1. This group had no change in either serum T_4 index or T_3 RIA. Although no data on long-term follow-up was reported, it was concluded that there was a large number of elderly subjects with failing thyroid glands. It is highly probable that those individuals with failing thyroid glands will present with clinically overt hypothyroidism unless some intervention is made. Cautious replacement therapy with L-thyroxine, starting at 0.025 mg, should probably be initiated in the elderly subject with elevated serum TSH despite normal serum T_4 or T_3 values. This will prevent clinical hypothyroidism from manifesting and also reduce the stimulus to thyroid nodule formation; *ie,* elevated TSH. A TSH secreting pituitary adenoma is so rare that examination should be undertaken only if TSH levels fail to decline after adequate thyroid hormone replacement. It remains highly controversial whether to initiate thyroid hormone treatment in those elderly subjects with only slightly elevated TSH levels. Long-term follow-up of this group will provide much needed data

as to the risk of this group developing hypothyroidism.

Once clinically suspect, the diagnosis of primary hypothyroidism can be confirmed by laboratory testing. An elevated serum TSH confirms the diagnosis when accompanied by depressed levels of T_4 and T_3 by RIA. It is important to remember, however, that serum TSH will climb first in an attempt to preserve the euthyroid state. Serum T_4 declines after and serum T_3 falls last leaving the individual no longer able to maintain euthyroidism. Although quite uncommon, hypothyroidism due to a pituitary tumor or pituitary-hypothalamic dysfunction should be considered when one finds a low serum TSH in the presence of low thyroid function studies.

Treatment of hypothyroidism in the elderly should be cautious. The most commonly used and acceptable preparation for replacement is L-thyroxine. Although in younger subjects average maintenance doses average 0.15 mg per day, recent data suggest that elderly subjects require somewhat less.[11] Because of the often coincident findings of coronary insufficiency, myocardial infarction and arrhythmias, and the increased sensitivity by tissues to thyroid hormone in hypothyroidism, initial dosage of thyroid hormone should be 0.025 mg per day. Gradual increases in dosage should be made only after relatively long intervals of two to four weeks with close monitoring. If adverse side-effects develop on a dosage prior to reaching a maintenance level, a dose reduction may be necessary. The normal range for serum thyroxine is quite large and caution must be exercised to not overly treat the elderly person. Monitoring serum TSH for return to within normal range is probably the best indicator of an individual reaching euthyroid status. Once a maintenance dose of L-thyroxine is determined, little change should be expected throughout life, although dosage does appear to vary slightly with increasing age and body mass. It is important to remember that it is often necessary to maintain an elderly subject at a borderline hypothyroid state rather than induce too much oxygen demand on the myocardium by returning laboratory values to normal. Each case must be considered individually and replacement dosages titrated.

Briefly, replacement therapy with T_3 or combination T_4 and T_3 is not advised. Beside a twice daily dosage, T_3 exerts a "burst" effect which may not be well-tolerated by the aging cardiovascular system. In addition, T_4 is converted by body tissues to T_3 as needed making the usage of the latter unnecessary. Thyroid gland extract has no benefit over L-thyroxine and may be subject to batch variation making management less than optimal.

SUMMARY. The elderly have a significant number of thyroid hormone problems. The clinician must be aware of the often altered presentation of hyperthyroidism in the elderly and recognize the early case of hypothyroidism, despite its resemblance to aging itself. Treatment should be initiated without delay, though caution is advised to avoid complications.

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—Photos for Geriatric Medicine series by Brent Nicastro

THE STATE MEDICAL SOCIETY OF WISCONSIN

*Created by the Territorial Legislature in 1841. . .*representing over 5,000 member physicians in Wisconsin, comprising 55 county medical societies and 23 medical specialty sections. The purpose of the Society is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society include continuing medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, services for physicians, operation of a Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal.*

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SMS Board raps DHSS on uniform fee schedule release

Following its meeting in Prairie du Chien July 17, the SMS Board of Directors communicated its displeasure to Dept of Health and Social Services Secretary Donald Percy concerning his department's releasing its proposal for modifying physician reimbursement in the Medicaid program prior to SMS Board review of an advisory committee report on the matter.

At the request of the Department last fall, the Society appointed a 15-member Advisory Committee on Physician Reimbursement to provide advice and reaction to the specifics of the proposal. After several meetings, the Committee's final report and response from the SMS Board of Directors were preempted by the Department July 9 when it released the details of the plan to the media and physicians.

SMS Board Chairman Darold A Treffert, MD and SMS President Gerald C Kempthorne, MD stated in a letter dated July 26 that releasing the report without the Society's knowledge not only rendered the Society's comments meaningless but also unfairly implied that the Society had officially supported or accepted the Department's proposal. "Despite the Department's oft-stated pleas for cooperation and trust, such a breach of faith severely strains your credibility with physicians," they said.

Since the true impact of the Maximum Allowable Fee (MAF) plan will vary from physician to physician with the possibility of advantage to some and disadvantage to others, each physician must consider the impact of this new system on his/her individual practice and act accordingly, the Board advises.

By now all physicians should have received a letter from SMS Board Chairman Treffert outlining the details of the new T-19 payment methodology effective October 1, 1982 and the concerns the Society's Advisory Committee and Board of Directors had with parts of the proposal.

In other action July 17 the Board:

• Endorsed an SMS Legislative Program for 1983. This legislative agenda will be used in candidate interviews in August and will be prepared in the form of a formal report for distribution to the SMS membership in the near future.

• Heard a report from SMS Mental Health Committee Chairperson Pauline M Jackson, MD, La Crosse, regarding the outcome of the Society's psychotherapy suit against the State Dept of Health and Social Services (DHSS) and the Federal Dept of Health and Human Services (HHS). The Board agreed with the Committee's recommendation to continue discussions with DHSS and HHS to seek modifications of the Medicaid program to allow reimbursement for services rendered to Medicaid patients by psychiatrists. While Judge Barbara Crabb denied the Society's request for an injunction at this time, her decision reaffirmed the Society's contention that psychiatrists are physicians under the Medicaid program and therefore their services are mandated by Federal law. Under Judge Crabb's order, DHSS has until August 31 to respond to Federal government requests for additional information. In the event the State does not comply with this order, SMS will have further cause for action.

• Authorized the Society to use every legal means to nullify a subpoena seeking SMS Impaired Physician Program records for use in civil suit by a patient against a physician. SMS contends peer review records are confidential and are not subject to public inspection. The Board said turning over such records would destroy the confidence of physicians, complainants and others in the Society's peer review program.

• Voted to convert the DHSS Advisory Committee on T-19 Reimbursement to a Continuing Committee on Reimbursement Methodolgy under the jurisdiction of the SMS Physicians Alliance Commission. Committee members will remain the same. In addition to discussing reimbursement alternatives in both the public and private sectors, the Committee was assigned responsibility for studying a Medicaid Tax Credit Concept and a proposal of the Wisconsin Academy of Family Physicians for Medicaid reimbursement using a combination of usual-customary-reasonable (UCR) payment with a corridor of free care.

• Adopted a position that SMS maintain its firm commitment to the Wisconsin Health Care Liability Insurance Plan (WHCLIP) and urged the continued support of its operations. Jung K Park, MD, Wisconsin Rapids, reported on his attendance at a July hearing ordered by the WHCLIP Board which discussed proposals to either terminate WHCLIP or transfer its operations to the State Medical Society or some other private sponsor.

• Approved a reccomendation from the Society's Committee on School Health to endorse a policy and model forms relating to "administration of medication in schools" for both injectable and oral medications. Staff is directed to make the policy and sample forms available to Wisconsin School Districts, physicians, and the American Medical Association.

• Made the following appointments to SMS Commissions and Committees: Commission on Health Planning—*Sidney Johnson, MD,* Marshfield; Commitee on Aging and Extended Care Facilities—*Robert E Phillips, MD,* Marshfield, and *Conrad L Andringa, MD,* Madison. (Please update the July *WMJ* BLUE BOOK) ■

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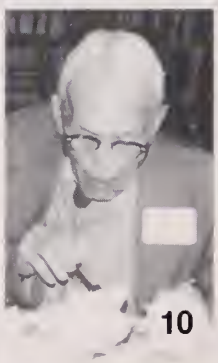
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Museum welcomes senior physicians

About 25 senior physicians and their spouses spent a relaxing day June 22 learning more about their medical heritage and each other during a special trip to the Fort Crawford Medical Museum at Prairie du Chien sponsored by the Wisconsin Association for Senior Physicians.

The day began with physicians boarding a chartered bus in Milwaukee and traveling to SMS headquarters in Madison to pick up the remainder of the group.

Upon reaching Prairie du Chien, physicians and their spouses were treated to a delightful luncheon prepared by the Methodist Church Auxiliary.

That afternoon, Museum staff conducted guided tours for the group, and in the process learned a little more about medical history from the senior physicians! Karver L Puestow, MD, Madison, captivated the group by conducting his own personal demonstration on how to use an esophageal dilator he recently donated to the Museum.

Certainly, the day was one of intellectual and social enrichment for all. (See photos on opposite page.)

Officers of the WASP are: Norman A Clausen, MD, Mazomanie, president; Paul J Collopy, MD, Milwaukee, president-elect; Howard L Correll, MD, Arena, secretary-treasurer. These three officers and Thomas A Leonard, MD, Madison, ex officio, comprise the executive committee. ■

SENIOR PHYSICIANS pictured on opposite page:

1. August J Jurishica, MD & Mrs Jurishica
2. Mrs Buscaglia; T E Gundersen, MD; Mrs Nordholm; Mrs Correll; Chris J Buscaglia, MD; Norman Clausen, MD
3. Howard L Correll, MD; Mrs Correll; Robin N Allin, MD
4. Norman Clausen, MD; George H Handy, MD
5. Thomas A Leonard, MD; Eli M Dessloch, MD
6. T E Gundersen, MD; Mrs Clausen; Norman Clausen, MD; Howard Correll, MD; Earl R Thayer; Mrs Nordholm; Vincent W Nordholm, MD
7. Karver L Puestow, MD
8. L E Haushalter, MD
9. Chris J Buscaglia, MD
10. Homer Carter, MD
11. Guy W Carlson, MD
12. Erwin J Jelenchick, MD
13. Vincent W Nordholm, MD

—Staff photos by Bill Wendle

SENIOR PHYSICIANS and spouses on front lawn of Fort Crawford Military Hospital, a historic landmark which is part of the Museum of Medical Progress in Prairie du Chien. Left to right: Robin N Allin, MD; Mrs Allin; Mrs Clausen; L E Haushalter, MD; Mrs Haushalter; August J Jurishica; Norman Clausen, MD; Mrs Jurishica; Mrs Jelenchick; Erwin J Jelenchick, MD; Mrs Handy; Mrs Nordholm; George H Handy, MD; Vincent W Nordholm, MD; Homer Carter, MD; Thorolf E Gundersen, MD; Mrs Puestow; Thomas A Leonard, MD; Chris J Buscaglia, MD; Guy W Carlson, MD; Karver L Puestow, MD; and Mrs Buscaglia. (Staff photo by Bill Wendle)

CME accreditation site surveyors needed

The Society's Commission on Continuing Medical Education, through its Subcommittee on Accreditation, is seeking additional surveyors for site visits to accredit hospital, specialty society, and county society continuing medical education programs.

According to Commission chairman, James T Houlihan, MD, Woodruff, there are no special qualifications or limitations for physicians who wish to serve; there is no age barrier, and all specialties and any degree of involvement are acceptable. Physicians may serve as little as once a year or as many times as they wish. Physicians unfamiliar with the site surveys will accompany experienced surveyors three or four times before being asked to write a report, Doctor Houlihan noted.

Since 1974 the Society's accreditation program surveyors have reviewed 128 hospitals, 61 specialty society, and 4 county medical society CME programs. Currently the State Medical Society and the American Medical Association have accredited 54 hospitals and 26 specialty societies, and 1 county medical society.

If any member is interested in participating in site survey visits, contact SMS offices in Madison: Arlene Meyer or Bill Wendle at 608/257-6781 or toll-free 1-800-362-9080. ■

A 'thank you' to CME site surveyors

The SMS Commission on Continuing Medical Education wishes to thank its Subcommittee on Accreditation and the 74 surveyors who have completed at least one site survey during the period December 1974 to September 1, 1982. One of the surveyors has completed 20 (§) surveys; eight have completed 10 or more (*); and 14 have completed 5 or more (†) surveys.

Surveyors are listed below in alphabetical order. Members of the Subcommittee on Accreditation are noted with (SOA).

Richard D Adelman, MD, Oshkosh
John Allen, MD, Wausau
Irving J Ansfield, DO, Milwaukee
Tom Arnfeldt, Madison (Admin Asst to Director of Medical Education, Madison General Hospital)
Timothy J Bauer, PA-C, Tomah (Director of Education)
Edwin L Banaszak, MD, Milwaukee
†Jerold J Beerends, MD, West Bend (SOA)
Kathy Belgea, MD, Wausau
Edwin L Bemis, MD, Milwaukee
*George A Berglund, MD, Milwaukee
J M B Bloodworth Jr, MD, Madison
†Howard Chirstensen, Madison (CME Coordinator, Madison General Hospital)
Timothy A Correll, MD, Dodgeville
*Andrew E Cyrus Jr, MD, Sheboygan
Willard Duff, PhD, Milwaukee
Richard W Edwards, MD, Richland Center
Arnold A Effron, MD, Cudahy
†Chesley P Erwin, MD, Milwaukee
Robert J Fink, MD, Eau Claire
Paul M Fleming, MD, Sheboygan
†Martin Z Fruchtman, MD, Waukesha
§Bradley G Garber, MD, Osseo (SOA Chrmn)
*Paul B Glunz, MD, Beaver Dam (SOA)
Kenneth I Gold, MD, Beloit
Paul W Grotenhuis, MD, Rhinelander
*George H Handy, MD, Madison
†George C Hank, MD, Madison
Ray C Haselby, DO, Marshfield
†William E Hein, MD, New Glarus
Robert D Heinen, MD, Stockbridge
Richard C Henry, MD, Reedsburg (Deceased)
†Erwin O Hirsch, MD, Milwaukee
Warren J Holtey, MD, Marshfield (SOA)
†James T Houlihan, MD, Woodruff
*Melvin F Huth, MD, Baraboo (SOA)
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†John F Kuglitsch, MD, Fond du Lac
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James M Lewis, MD, Baraboo
Richard D Lindgren, MD, Madison
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Paul B McAvoy, MD, Neenah
John E McKenna, MD, Antigo
Henry R Mol, MD, Elkhorn
Albert J Motzel Jr, MD, Waukesha
W Eugene Musser, MD, Madison (SOA)
*John A Nelson, MD, Madison
†Thomas F Nikolai, MD, Marshfield
*Edwin L Overholt, MD, LaCrosse
Jung K Park, MD, Wisconsin Rapids
John A Palese, MD, Milwaukee
S Fevzi Pamukcu, MD, Kenosha
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David C Reynolds, Madison
Benson L Richardson, MD, Green Bay
Kendall E Sauter, MD, Milwaukee
*Richard D Sautter, MD, Marshfield (SOA)
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The Physician's Sleep Glossary

Some common sleep laboratory terms

poly•som•no•graph. An instrument which simultaneously records by electrodes physiological variables during sleep—for example, brain activity (EEG), eye movements (EOG), muscle tonus (EMG) and other electrophysiological variables. These readings indicate precisely when patients fall asleep, how many wake periods they experience, the quality of sleep and the duration of sleep.

sleep la•ten•cy. The period of time measured from "lights out," or bedtime, to the commencement or onset of sleep.

wake time af•ter sleep on•set. Intervals of time spent awake between onset of sleep and the end of the sleep period. The polysomnograph registers the length and frequency of the intervals.

to•tal sleep time. The amount of time actually spent in sleeping. This is estimated by subtracting wake times from the period encompassed by the onset and the termination of sleep.[1]

REM/NREM. 1. REM, or rapid eye movement, sleep is "active"—characterized by increased metabolic rates, elevated temperature and arousal-type EEG patterns. 2. NREM, or non-rapid eye movement, sleep represents "quiet" sleep stages. There are four distinct stages of NREM sleep.[2]

re•bound in•som•nia. A statistically significant worsening of sleep compared to baseline on the nights immediately following discontinuation of sleep medication.[3]

References: 1. Williams RL, Karacan I: Introduction, chap. 1, in *Sleep Disorders: Diagnosis and Treatment*, edited by Williams RL, Karacan I, Frazier SH. New York, John Wiley & Sons, 1978, p. 2. **2.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **3.** Kales A *et al: JAMA 241:*1692-1695, Apr 20, 1979. **4.** Kales A *et al: J Clin Pharmacol 17:*207-213, Apr 1977 and data on file, Hoffmann-La Roche Inc., Nutley, NJ. **5.** Kales A: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **6.** Kales A *et al: Clin Pharmacol Ther 19:*576-583, May 1976. **7.** Kales A, Scharf MB, Kales JD: *Science 201:*1039-1041, Sep 15, 1978. **8.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27:*541-546, Dec 1979. **9.** Dement WC *et al: Behav Med 5*(10):25-31, Oct 1978. **10.** Vogel GW: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **11.** Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington, DC, May 3-7, 1971. **12.** Pollak CP, McGregor PA, Weitzman ED: The effects of flurazepam on daytime sleep after acute sleep-wake cycle reversal. Presented at the 15th annual meeting of the Association for Psychophysiological Study of Sleep, Edinburgh, Scotland, June 30-July 4, 1975. **13.** Zimmerman AM: *Curr Ther Res 13:*18-22, Jan 1971. **14.** Kales A, Kales JD: *Pharmacol Physicians 4*(9):1-6, Sep 1970. **15.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ.

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Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

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Civil War troops assemble at Medical Museum

It was the Civil War revisited July 17 and 18 at the Fort Crawford Medical Museum at Prairie du Chien.

Civil War Encampment groups from throughout the Midwest assembled on the Museum grounds and established Union and Confederate camps.

In addition to seeing soldiers outfitted with the authentic blue and gray uniforms, firearms and equipment, the 1,000 visitors to the Museum that weekend witnessed civil war battles, marching drills, and cannon firing demonstrations.

The living history reenactment at the Medical Museum in Prairie du Chien was held in conjunction with an SMS Board of Directors meeting and the Annual Meeting of the Society's Charitable, Educational, and Scientific Foundation.

The event had special historical significance for the Medical Museum. The reconstructed military hospital at Fort Crawford was used for the wounded of both armies. In addition, Jefferson Davis, the only President of the Confederacy once served at Fort Crawford.

The Aesculapian Society, which manages the Fort Crawford Medical Museum, hopes to make the Civil War Encampment an annual event. ■

CES FOUNDATION

CONTRIBUTIONS—JUNE 1982

The Charitable, Educational and Scientific Foundation of the State Medical Society is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for June 1982.

Restricted

Doctors' Clinic of Wisconsin Rapids; Richard O Barnes, MD; Tuenis D Zondag, MD; Richard Ellingstad, MD; WH Williamson, MD—*Medical Student Summer Externship Program*

Marathon County Medical Auxiliary—*Marathon County Medical Society Auxiliary (Student Loan Fund)*

William O Meyers, MD; Robin N Allin, MD—*Museum of Medical Progress (Endowment Fund)*

Marion Crownhart—*Beaumont "500" Club*

Memorials

Dr-Mrs Gerald C Kempthorne—*Mr Shawn Riley*

Dane County Medical Society—*Edwin F Schneiders, MD*

Dr-Mrs Jewel Huebner—*LC Gardner, MD*

Dr-Mrs Wm P Curran—*Mrs Irene Ouweneel; Ervin L Bernhart, MD; Albert C Schmidt, MD; Ralph C Frank, MD*

State Medical Society—*Adeline Mulock; Isadore B Reifenrath, MD; Vitoldas Balciunas, MD; George W Wegmann, MD; Louis S Stern, MD; Clifford F Broderick, MD* ■

SMS Services, Inc Board okays new insurance plans

The SMS Services, Inc Board of Directors met in Prairie du Chien July 16 and took the following actions:

• Endorsed two new insurance plans: (1) *Income Replacement*—an innovative insurance plan which is superior to traditional long-term disability income plans, and (2) *Insured Medical Reimbursement Plan*—this plan is designed with definite tax advantages when paying expenses not covered by regular health insurance.

• Approved renewal of members' group disability income plan with Provident Life and Accident Insurance Company.

• Established September 16, 1982 as the date for the next Personal Financial Planning Seminar to be held at the Brookfield Marriott.

• Heard a report that SMS Services, Inc insurance agency operations now consist of over $4 million in annualized premium. ■

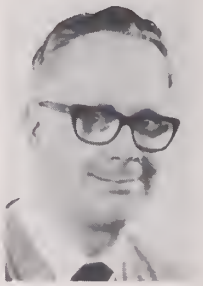
SMS Services plans Personal Financial Planning seminar

The SMS Board of Directors has set September 16 as the date for the next Personal Financial Planning seminar. The sessions will be held at the Marriott Inn, Brookfield, and will run the full day. Designed to focus on such subjects as investment planning, retirement plans, and estate planning, participants will also be updated on laws and regulations passed since the last extremely successful seminar held on these subjects. The faculty will be the same highly qualified lawyers who conducted last year's seminar. Since personal finances are quite often a team effort, spouses are encouraged to attend. If you take an active part in your own finances, this is an excellent opportunity to learn more about the subject. So, set aside September 16. ■

Dr George Kindschi, Monroe named to Editorial Board

George W Kindschi, MD, Monroe, was appointed to the Editorial Board of the *Wisconsin Medical Journal* by the SMS Board of Directors when it met in May during the Annual Meeting.

Doctor Kindschi follows in his father's footsteps. Leslie G Kindschi, MD, also of Monroe, served on the Editorial Board for over 17 years. The younger Doctor Kindschi succeeds Harold H Scudamore, MD of Monroe.



Dr Kindschi

Doctor Kindschi, a pathologist, joined the Monroe Clinic in 1976 after serving as a staff pathologist at the Great Lakes Naval Hospital. He graduated from the University of Wisconsin Medical School, Madison, served a rotating internship at Great Lakes Naval Hospital, then served a four-year pathology residency at Bethesda Naval Hospital.

He was an associate clinical professor of pathology and allied health at George Washington University, Washington, DC; an assistant professor of pathology at the Chicago Medical School; and an assistant professor of pathology at the University of Wisconsin Medical School in Madison. ■

Blue Book–Update

In the listing on page 109 of the July 1982 BLUE BOOK, under the Commission on Health Planning, the following corrections should be made:

Peter L Eichman, MD, Madison, 1984
Jan E Erlandson, MD, Monroe, 1984.

Also add Sidney Johnson, MD, Marshfield, 1985, to the Health Planning Commission.

On page 118 under president and secretaries, Wisconsin Specialty Societies, the new secretary of the Wisconsin Chapter, American College of Emergency Physicians is:

Eugene H Kastenson, MD (Oct 1982)
4315 Pennington Lane
Racine, WI 53403

On page 111 under the Committee on Aging and Extended Care Facilities add the following:

Robert E Phillips, MD, Marshfield, 1985
Conrad L Andringa, MD, Madison, 1985. ■

MEMBERSHIP UPDATE

The following physicians, by county medical society, have recently been elected to membership, or have been reelected or reinstated since publication of the Membership Directory in the January issue of the *Wisconsin Medical Journal,* with the specialty abbreviated above the name:

BROWN

NPM PD
Pokora, Thomas J
900 S Webster Ave
Green Bay WI 54301

D DMP
Smullen, Michael J
930 West Mason St
Green Bay WI 54303

CHIPPEWA

FP
Sanchez, Romulo M
Boyd WI 54726

DANE

CD IM
Bandow, George T
1313 Fish Hatchery Rd
Madison WI 53715

GE IM
Browning, Thomas H
1050 Regent St
Madison WI 53715

AN
Burner, Richard W
5309 Comanche Way
Madison WI 53704

Dzelzkalus, John J
1767 Norman Way
Madison WI 53705

PD PHO
Finlay, Jonathan L
12640 Corte Madera Ln
Los Altos Hills CA 94022

GS
Glass, Neal R
H4/366 CSC
600 Highland Ave
Madison WI 53792

Jacobson, Kirk
2302 University Ave, #312
Madison WI 53705

IM ID
Reich, Richard M
4117 E Washington Ave
Madison WI 53704

GE IM
Reichelderfer, Mark
1050 Regent St
Madison WI 53715

Robinson, James C
1026 Drake St
Madison WI 53715

Roddy, Timothy J
1116 E Mifflin St, #6
Madison WI 53703

DOOR-KEWAUNEE

ORS
Schueppert, Thomas
PO Box 447
Sturgeon Bay WI 54235

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FP
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1514 Ogden Ave
Superior WI 54880

GRANT

Stone, Mildred M S
507 E Webster St
Cuba City WI 53807

GREEN

NS
Choo, Sin Huat
1515 10th St
Monroe WI 53566

GREEN LAKE-WAUSHARA

IM PUD
Tomana Jr, Teodora P
POB 117
Wild Rose WI 54984

JEFFERSON

OPH
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123 Hospital Dr, #208
Watertown WI 53094

KENOSHA

FP
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Kenosha WI 53140

LA CROSSE

IM
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1836 South Ave
La Crosse WI 54601

MARATHON

Brodhead, Richard H
2213 Ridge View Dr
Wausau WI 54401

MILWAUKEE

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Ansari, Shapoor S
3112 W Highland Blvd
Milwaukee WI 53208

PD
Dunigan, Thomas H
3417 South 44th St
Greenfield WI 53219

IM
Gleeson, Robert K
720 E Wisconsin Ave
Milwaukee WI 53202

OPH
Haimann, Mark H
8620 N Port Washington, #214
Milwaukee WI 53217

A IM
Hirsch, S Roger
5810 W Oklahoma Ave
Milwaukee WI 53219

ORS
Krug, Alvin K
9400 West Lincoln
West Allis WI 53227

D
Parke-Miller, Pamela
2500 N Mayfair Rd
Milwaukee WI 53226

OPH
Schott, Jean H
811 E Wisconsin Ave
Milwaukee WI 53202

Trumm, Paulette C
2628 N Weil St
Milwaukee WI 53212

Wiedmeyer, Debra A
9231 W Wisconsin Ave, #1
Milwaukee WI 53226

OBG
Worthington, Dennis
8700 W Wisconsin Ave
Milwaukee WI 53226

OZAUKEE

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326 West Pierre Ln
Port Washington WI 53074

POLK

FP
Peterson, Timothy J
Frederic WI 54837

RACINE

EM GS
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6031 N Kent Ave
Milwaukee WI 53217

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AN
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1458 N Parker Dr
Janesville WI 53545

AN
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IM
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4828 West Donges Bay
Mequon WI 53092

Hubbard, Robert F
434 Madison St
Waukesha WI 53186

FP
Grebner, James V
434 Madison St
Waukesha WI 53186

WINNEBAGO

EM FP
Bowers, Timothy L
631 Hazel St
Oshkosh WI 54902

EM
Byrne, Thomas F
2243 Sunrise Dr
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P
Hachfeld, Douglas A
POB H
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Obituaries

Alex Martin Kane, MD, 74, Wauwatosa, died Apr 3, 1982 in Milwaukee. Born Mar 18, 1908 in Chelsea, Mass, Doctor Kane graduated from the University of Wisconsin Medical School, Madison, and served his internship and residency at Milwaukee County General Hospital. He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association. Surviving are his widow, Dorothy; and three sons, Michael, Wilmette, Ill; Neal, Iowa City, Ia; and Howard of Milwaukee.

George H Wegmann, MD, 75, Wauwatosa, died Apr 21, 1982 in Wauwatosa. Born June 5, 1906 in Beaver Dam, Doctor Wegmann graduated from the University of Wisconsin Medical School, Madison, in 1932 and served his internship at Milwaukee Passavant Hospital and residency at Milwaukee Children's Hospital. Doctor Wegmann began his medical practice in 1936 and from 1943-1946 he served in the United States Army Medical Corps. He was on the medical staff of Milwaukee Children's Hospital and served as chief of staff from 1959-1965. He was an associate clinical professor of pediatrics at the Medical College of Wisconsin and retired from medical practice in 1977. He was a member of the "50 Year Club" of the State Medical Society of Wisconsin, a member of The Medical Society of Milwaukee County, and the American Medical Association. Surviving are his widow, Betty; a daughter, Mary Hinners of Brookfield; and two sons, Doctor Thomas G, Edmonton, Alberta, Canada, and Doctor John of Port Angeles, Wash.

Louis S Stern, MD, 74, Milwaukee area physician for 50 years, died Apr 26, 1982. Born Mar 1, 1908 in London, England, Doctor Stern graduated from Marquette University School of Medicine and served his internship at Evangelical Deaconess Hospital in Milwaukee. His residency was completed at Milwaukee General and Maternity Hospital. Doctor Stern served in the 92nd Division Medical Corps in World War II. He was on the medical staff of Mount Sinai Medical Center and Family Hospital. Doctor Stern was a member of the American Academy of Family Physicians, The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and the American Medical Association. Surviving are his widow, Hattie; two daughters, Judith King, Agoura, Calif, and Suzanne Geller of Poughkeepsie, New York.

John R Erickson, MD, 61, Stevens Point physician for more than 30 years, died Apr 30, 1982 in Stevens Point. Born June 22, 1920 in La Crosse, Doctor Erickson graduated from the University of Wisconsin Medical School, and served his internship at Milwaukee County General Hospital. He served in the United States Naval Medical Corps for two years and had practiced in Milwaukee for three years before moving to Stevens Point in 1951. Surviving are his widow, Trudy; four sons, Major Karl Erickson, Fort Benning, Ga; Leif, Andrew, and John all of Hilo, Hawaii; and two daughters, Mrs Calvin (Jan) Viloria, Hilo, Hawaii, and Karen of Honolulu, Hawaii.

Edward F Mielke, MD, 89, Appleton, died May 26, 1982 in Appleton. Born Dec 3, 1892 in Shawano, Doctor Mielke graduated from Rush Medical School, Chicago, and served his internship at Cook County Hospital and his residency at Augustana Hospital in Chicago. He served in the United States Army during World War I. He began his medical practice in Appleton in 1921 which he continued for 60 years. During his medical practice, he was on the staff of several area hospitals, including St Elizabeth where he remained on the staff until his death. Doctor Mielke was instrumental in establishing Appleton Memorial Hospital and was its first chief-of-staff. He was a member of the Outagamie County Medical Society, State Medical Society of Wisconsin, and American Medical Association. Surviving are his widow, Beulah; two daughters, Mrs Roy (Lois) Piekenpol, Potomac, Md; and Mrs Ellen Moore of Duluth, Minn; two sons, Dr John E, Appleton, and the Rev William C of Harrisburg, Pa.

Clifford F Broderick, MD, 71, Wisconsin Dells physician for 25 years, died May 8, 1982 in Atlanta, Ga. Born Apr 2, 1911 in Fond du Lac, Doctor Broderick graduated from Marquette University School of Medicine in 1935 and served his internship and residency at Milwaukee County Hospital. He practiced in Milwaukee from 1937-1944 and then served in the United States Navy from 1944-1946. In 1946 he began his medical practice in Wisconsin Dells and retired in 1971 due to ill health. He had served as chief of the medical staff at St Clare Hospital, Baraboo, and at Divine Savior Hospital in Portage. He was a Charter Fellow of the American Academy of Family Physicians. Prior to moving to Georgia a year ago, he had lived in Sun City, Ariz. Surviving are his widow, Ruth; two sons, Patrick, Peachtree City, Ga, and Thomas, Washington, DC; six daughters, Sheila O'Neil and Mary Locke, Topeka, Kan; Kathleen Stagney, Nashua, NH; Monica Cook, Columbus, Ohio; Rosemary, Phoenix, Ariz; Elizabeth of New York, and 16 grandchildren.

Ernest G Welke, MD, 93, Madison, died May 27, 1982 in Madison. Born Nov 15, 1888 in Fall Creek, Doctor Welke graduated from Marquette University School of Medicine in 1919 and served his internship at Madison General Hospital. He served in the United States Army during World War I. He was a member of the "Fifty Year Club" of the State Medical Society of Wisconsin, a member of the Dane County Medical Society, and American Medical Association. Surviving are a son, Joseph, Red Wing, Minn.; and two daughters, Dorothy McDonald, Madison; and Virginia Bonner, also of Madison.

Edwin F Schneiders, MD, 86, Madison, one of the founders of the Dean Clinic in Madison, died May 30, 1982 in Madison. Born Aug 15, 1895 in Marathon, Doctor Schneiders graduated from Harvard Medical School, Boston, Mass, in 1921 and served his internship and residency at Boston City Hospital. He served in the United States Army during World War I. He was a professor of Obstetrics and Gynecology of the University of Wisconsin

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Medical School, Madison, and had been an emeritus professor since 1965. He had been chief of Obstetrics and Gynecology and chief of the medical staff at St Marys Hospital Medical Center, Madison, for many years. During his career, Doctor Schneiders had delivered an estimated 10,000 babies. He retired from medical practice in 1971. He was a member of the Madison and Wisconsin societies of Obstetrics and Gynecology; American Cancer Society; American College of Obstetricians and Gynecologists; Central Association of Obstetrics and Gynecology; and was instrumental in developing the University of Wisconsin Medical School's collaborative residency and medical student programs in Madison hospitals. He also was a member of the Dane County Medical Society, State Medical Society of Wisconsin, and American Medical Association. Surviving are his widow, Violet; four daughters, Mrs Betty Sonneland, Madison; Mrs Suzanne Harnischfeger and Mrs Rosemary Fritz, both of Milwaukee; and Mrs Nancy McLaughlin, Atlanta, Ga; and a son, Edward of Darien, Conn.

Henry Freund, MD, 85, Milwaukee, died June 19, 1982 in Milwaukee. Born Nov 23, 1896 in Vukovar, Yugoslavia, Doctor Freund graduated from the University of Vienna School of Medicine, Austria, and served his residency at Strong Memorial Hospital in Rochester, New York. He was on the medical staff of the Mental Hygiene Clinic, Veterans Administration Regional Office in Milwaukee for many years. Surviving are his widow, Julie, and a daughter, Vera Reich of Honolulu, Hawaii. ■

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SMS President testifies on Medical Board standards

A "laundry list" of standards for medical practice would do nothing to protect the patient and may even be to his/her detriment, SMS President Gerald C Kempthorne, MD, Spring Green, told members of the Medical Examining Board July 14.

Doctor Kempthorne made his remarks at a public hearing held by the Board in response to concerns raised by the Legislature's Joint Committee for Review of Administrative Rules regarding the adequacy of the unprofessional conduct standard in assessing physician negligence.

He said that such exact and inflexible guidelines would soon become outdated due to rapidly advancing medical knowledge and technology.

Furthermore, the President pointed out that "the situation and details surrounding any one 'case' involving a question of acceptable medical practice or physician competence are almost always unique to that case."

On the issue of due process and investigatory procedures used by the Board and the Department, the SMS President said this was an area which is "ripe for refinement."

"Investigations that fail to involve early interaction with the physician in question are inappropriate and subject the physician to unwarranted harassment," he said. Doctor Kempthorne urged the Board utilize a well-defined protocol and to communicate details of the investigatory process to physicians and patients to alleviate confusion and mistrust of Board activity.

Instead of referring all Patient Compensation Panel findings of negligence to the Board, Doctor Kempthorne suggested that negligence findings be considered reasonable cause for peer review.

"A single act of negligence does not necessarily constitute unprofessional conduct and therefore should not trigger a licensing review," he said. ■

T-19 Program looking at prepaid contracts

Earlier this year the Wisconsin Department of Health and Social Services (DHSS) applied for a federal waiver to the Wisconsin Medicaid Program to permit the use of the prepaid agreements with healthcare providers. DHSS has received *preliminary* authority to proceed with this concept. DHSS is now seeking contractual arrangements with physicians and groups of physicians in the Milwaukee area for the delivery of services to that county's Medicaid recipients. The Department hopes to proceed in three ways: (1) through the use of contractual arrangements with HMOs; (2) Primary Care Networks involving physician groups or clinics; and (3) a basic Primary Provider Program which would utilize single physicians for all nonemergency care. In all of these approaches, the recipient would be "locked into" a designated physician provider. The Department would like to discuss these three approaches with any interested physician. For further information, contact Tom Lovett, Division of Health, (608) 266-2446. ■

Federal legislation focus on pension, budget bills

The Committee on Federal Legislation (FLC) met July 14 to discuss some controversial issues currently up before Congress. Specifically, Committee discussions focused on two issues of special interest to organized medicine:

• **First Concurrent Budget Resolution for FY83**—The resolution, which was adopted by both Houses of Congress on June 23, calls for spending reductions in Medicare of $3.2 billion and reductions in Medicaid of $674 million. The day after the resolution passed, the Senate Finance Committee approved its package of savings proposals for Medicare and Medicaid. FLC members discussed the savings proposals that affect physicians participating in the Medicare program and expressed concern that some of the proposals would have the effect of regulating physicians' income. FLC's comments on the proposals will be directed to the Senate Finance Committee prior to full Senate consideration which is expected in August.

• **Pension Equity Tax Act of 1982 (HR 6410)**—This controversial legislation would have a major impact on corporate pension plans—particularly the pension plans of professional corporations by making their retirement plans subject to the same rules as Keogh plans. FLC members agreed to oppose HR 6410 but to support one aspect of the bill to raise the maximum Keogh contribution from $15,000 to $30,000. This position will be communicated to the House Ways & Means Committee as well as to the Wisconsin Delegation.

The committee is also monitoring legislation that relates to the jurisdiction of the Federal Trade Commission, professional standards review organizations, health planning, and pro-competition. ■

No final conclusions on psychotherapy issue

Federal District Judge Barbara Crabb June 25 denied a State Medical Society request to preliminarily enjoin further implementation of Wisconsin's prior-authorization plan for Medicaid-financed psychiatric services. While the judge did not grant the motion, she suggested that SMS submit a renewed motion for injunction if the State has not responded to US Department of Health and Human Services' requests for additional information within 45 days of her order. Secretary Schweiker has previously seriously questioned the legality of the Wisconsin scheme.

In her 25-page opinion, Judge Crabb concluded that "all regular and customary services provided by psychiatrists in the care and treatment of the patients, including psychotherapy, are physicians' services within the meaning of subsection (5) of s. 139(d)(a) and, as such, are mandatory services under state medical assistance plans." She did not address the question of whether the State law or the Department's handling of psychiatry services is presently in violation of her finding.

She also found that "discrepancies among 51.42 Boards in the services for which they provide coverage, in their willingness to contract with psychiatrists in private practice, and in their reimbursement policies tend to bear out plaintiff's contention that, in its present form, Wisconsin's gatekeeper system does not comply with the requirements of federal law. However, she contended that because the Secretary of HHS is still considering a proposed waiver requested by the State, these problems "lack ripeness for adjudication."

Judge Crabb said that plaintiffs failed to show that the gatekeeper system will reduce the level of services available to mentally ill Medicaid recipients, and also failed to show that physicians would suffer irreparable harm if the motion for injunction relief was denied. It is ironic because the conscientiousness of physicians evidenced through the continued delivery of mental health services has resulted in the court finding an absence of irreparable harm.

In light of Judge Crabb's decision, significant responsibility is now placed on the State to revise the community mental health board-gatekeeper system. ■

SOME OF THE MOST IMPORTANT WORK FOR CANCER IS BEING DONE OUTSIDE THE LAB.

It's being done in automobiles and living rooms. Over coffee and cake. By people like Madeline Mitza and Theresa Barbieri.

They met when Madeline was in treatment for breast cancer and Theresa was the volunteer who drove her to her therapy appointments. Now, like Theresa, Madeline is bringing help and hope to other women as a Reach to Recovery volunteer.

Madeline and Theresa are living proof that it's people who give people the will to live. The work in the lab must continue. And so must the work outside. We need your help.

SHARE THE COST OF LIVING

Give to the American Cancer Society.

SAUK: Earlier this year the Sauk County Medical Society honored Spring Green family physician Gerald C Kempthorne, MD* in recognition of his recent installation as the 127th president of the State Medical Society of Wisconsin. Doctor Kempthorne has held several posts in organized medicine at the state and county levels. He is a former president and secretary of the Sauk CMS and for the past three years has served on the SMS's Board of Directors. As chairman of the SMS's Commission on Mediation and Peer Review, Doctor Kempthorne has been a major participant in establishing a comprehensive statewide program for helping physicians impaired by alcohol, other drugs, or emotional and physical disorders.

Robert H Mortimore, MD,* Reedsburg (left), and Earl R Thayer, Madison (right), presenting plaque to Gerald C Kempthorne, MD,* Spring Green, in recognition of Doctor Kempthorne's election to the presidency of the State Medical Society. Doctor Mortimore is president of Sauk CMS and Mr Thayer is secretary of the SMS. (Staff photo by Lanny Hardy)

WINNEBAGO: At the June meeting of the Winnebago County Medical Society, the guest speaker was John Phair, MD, Professor of Medicine and Head of Infectious Disease at Northwestern University, Chicago. He spoke on "Prophylactic Antibiotics in Surgery."

Officers were elected as follows: Roy E Buck, MD,* Neenah, president; Richard W Robert, MD,* Oshkosh, president-elect; and Edwin L Downing, MD,* Oshkosh, secretary-treasurer. There were 39 members and four guests at the meeting.

GREEN: During the annual meeting of the Green County Medical Society earlier this year in Monroe, the following MDs were elected as its new officers for 1982-84. They are: Geoffrey L Tullett,* Monroe, president; Jacob George,* Monroe, secretary-treasurer; Melvin S Blumenthal,* Monroe, and Jan E Erlandson,* Monroe, as delegates to the State Medical Society. Elected as alternate delegate was Velayudhan K Nair* also of Monroe. At a later meeting of the Society, the featured speaker was Theodore Goodfriend, MD, PhD, Professor of Pharmacology at the Veterans Administration Hospital in Madison.

POLK: Twenty-five members were present at the June meeting of the Polk County Medical Society to hear James Standifer, MD, Stillwater, Minnesota, present a paper on "Acute Traumatic Injuries to the Eye." Host for the evening was Daniel Schroeder, MD,* of Amery.

POLK: Fifteen members were present at the Spring meeting of the Polk County Medical Society to hear Dr Ismail Barrada, Director of Perinatal Service, United Hospitals, St Paul, Minn, present a paper on "Abnormal Labor Patterns." Host for the evening was Mark E Boyken, MD,* of St Croix Falls.

POLK: Charles Drage, MD, Head of Pulmonary Section at St Paul-Ramsey Hospital, Minn, and Brian Campian, MD, coordinator for St Paul-Ramsey Emergency Services, were the guest speakers at a recent meeting of the Polk County Medical Society. Marwood E Wegner, MD,* St Croix Falls, delegate to the State Medical Society Annual Meeting, reported on the meeting held in Milwaukee. Host for the evening was Arne T Lagus, MD.* Sixteen members were present.

WOOD: Twenty-one members were present at the May meeting of the Wood County Medical Society to hear Melvin C Chen, MD,* Marshfield, present a slide presentation on the basics of retinal surgery. The delegates to the State Medical Society Annual Meeting gave reports of the meeting and specifically discussed the proposed uniform fee schedule, and attempts by the State to not pay for certain physicians' fees by psychiatrists for outpatient Medicaid services and the zero blood alcohol concept.

OUTAGAMIE: At the June meeting of the Outagamie County Medical Society, honorary status for Arthur C Taylor, MD,* was approved, in recognition of his years of service and anticipated retirement from medical practice. The following MDs were elected to office and are: C William Freeby, MD,* president; John R Lindstrom, MD,* vice president; and Henry Chessin,* secretary-treasurer. The film entitled "The Last Epidemic" was shown. It was sponsored by the Physicians for Social Responsibility who are concerned with the medical and social implications of a nuclear holocaust. The annual picnic will be held at the September meeting. ■

IF YOU WISH TO HELP AN IMPAIRED PHYSICIAN

The State Medical Society of Wisconsin's Impaired Physician Program wishes to identify, intervene, and bring about the rehabilitation of physicians impaired by use of alcohol and other drugs, or mental or physical infirmity. Persons may call 608/257-6781 or toll-free: 800/362-9080 and explain their concern to Mr John LaBissoniere or Mr H B Maroney of the Impaired Physician program staff. The caller's identity will be kept in complete confidence. ■

Wisconsin Society of Internal Medicine and the American College of Physicians will hold their joint meeting in Green Bay at the Holiday Inn Downtown, September 9-11.

The first day, Thursday, will start off with the Eleventh Annual Tennis Tournament at the Oneida Country Club and the Sixteenth Annual Golf Tournament at the Brown County Country Club, both starting at 9:30 am.

Registration for the meeting will start at 3:00 pm and continue until 7:00 pm, Thursday; Friday registration, from 7:00 am to 3:00 pm; and Saturday, 7:30 to 9:00 am.

Welcoming remarks will start at 7:45 am Friday by Edwin L Overholt, MD,* FACP, La Crosse, Governor, Wisconsin, American College of Physicians and Council member, Wisconsin Society of Internal Medicine; Russell A Quirk, MD,* Racine, President, WSIM, and member, ACP; and Charles S Geiger, MD,* West Bend, scientific program chairman and WSIM Council member.

The scientific program begins at 8:00 am Friday and will consist of four sessions dealing with internal medicine problems as they relate to the pregnant patient:

Hypertension and pregnancy—Philip Dahlberg, MD,* La Crosse; *Cardiovascular disease and pregnancy*—Myrood Besozzi, MD,* Madison; *Diabetes and pregnancy*—Ronald Kalkhoff, MD, Milwaukee; and *Thrombocytopenia and pregnancy*—William Friedenberg, MD,* Marshfield.

The Middleton Memorial Lecture will be delivered by Richard J Reitemeier, MD, FACP, Department of Medicine, Mayo Clinic, Rochester, Minn. Presiding at the ACP luncheon will be Edwin L Overholt, MD,* FACP, Wisconsin Governor of ACP and WSIM Council member.

The WSIM/ACP annual banquet will be held Friday evening at 7:00 pm with a President's reception at 9:30 pm.

On Saturday the 8:00 am WSIM breakfast and business meeting will be presided over by WSIM President Russell A Quirk, MD,* Racine. Speaker will be Lonnie R Bristow, MD, president of the American Society of Internal Medicine.

The Saturday morning program will feature socio-economics, entitled *The Promised Land,* and will start at 9:00 am. S Spence Meighan, MD of Portland, Oregon will present the extraordinary tale of Dr Roderick McGregor and the time machine: a slide program depicting a physician who finds himself transported to a hospital 50 years in the future. Roundtable discussions will follow the presentation. An introduction will be given by James R Mattson, MD,* Green Bay, Socio-economic program chairman and WSIM Council member.

The program will adjourn at 12:00 noon. At 12:15 pm the WSIM Council will meet.

Further info: Wisconsin Society of Internal Medicine, 611 East Wells St, Milwaukee, Wis 53202.

Wisconsin Academy of Family Physicians held its Annual Meeting in La Crosse in June. The meeting coincided with "Family Physician Week" which was proclaimed by Governor Dreyfus for the week of June 13-19. Over 265 physicians and spouses attended.

During the meeting Richard W Edwards, MD,* Richland Center, was honored as "Family Physician of the Year" in Wisconsin for his dedication to his patients, his community, and his profession.

William E Scheckler, MD,* chairman of the Department of Family Medicine and Practice at the University of Wisconsin-Madison, was honored as "Family Practice Educator of the Year" for his efforts in educating the future family doctors of Wisconsin.

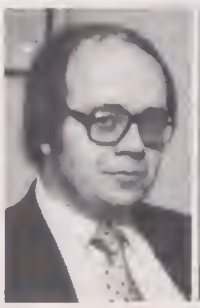
Jack Strong, MD,* Mauston, was installed as the new president, succeeding Charles L Steidinger, MD* of Platteville. Thomas H Peterson, MD,* Wausau, was elected president-elect, and David E Westgard, MD,* La Crosse, was elected secretary-treasurer.

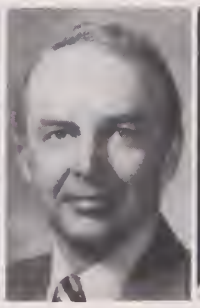
Also during the meeting delegates approved a resolution recommending that Medicaid reimbursements to physicians be based on a fixed schedule that is uniform regardless of physician specialty or geographic location. The delegates had been advised of the State Department of Health and Social Services' attempts to revamp its payment procedures under the Medical Assistance Program which currently includes a vast number of differing payments, based in part on the specialty of the physician and the location in which he practices. The resolution stated that one incentive for physicians to practice in poorer, rural areas of the state would be to reimburse them for services the same as physicians who practice in the more affluent urban areas.

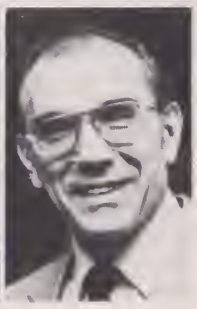
Delegates also addressed a problem affecting all physicians who deal with private health insurance companies.

Dr Edwards

Dr Scheckler


Dr Westgard


Dr Peterson


Dr Strong

Family Physician Week June 13-19

Governor Lee Dreyfus proclaimed the week of June 13-19 as "Family Physician Week" in Wisconsin. This coincided with the 34th annual meeting of the Wisconsin Academy of Family Physicians (WAFP) which was held June 16-19 at the Radisson Hotel in La Crosse (see adjacent story). At the signing ceremony in the Governor's office were (L-R): Gerald C Kempthorne, MD,* Spring Green, a member of the Academy and president of the State Medical Society; Governor Dreyfus; Charles L Steidinger, MD,* Platteville, president of WAFP; John O Grade, MD,* Elm Grove, chairman of the Board of Directors of WAFP; and Jack Strong, MD,* Mauston, president-elect of WAFP. (Photo courtesy Wisconsin Academy of Family Physicians)

Delegates were informed that some private insurance companies do not reimburse physicians for their usual, customary, and reasonable fees; and they imply to the patient that the insurance company sets or controls physicians' fees. The resolution asked these insurance companies to pay the physician's full usual, customary, and reasonable fee, or to properly explain to the patient before the patient purchases the policy what charges are covered by insurance and what charges are the responsibility of the patient. The resolution also called upon the insurance industry to cease the practice of implying that they are responsible for setting physicians' fees.

The Academy also went on record in favor of supporting the concept of an income tax deduction for physicians for those services provided to Medical Assistance patients who are not covered by Title 19. The Academy believes this would insure adequate physician coverage for all citizens of Wisconsin.

The Congress of Delegates approved the formation of a "Wisconsin Institute of Family Medicine," a non-profit organization dedicated to assisting the training of qualified family physicians in Wisconsin, to bring family health care to all areas of need in Wisconsin, and to promote research in family medicine.

In other actions the delegates:

. . . urged a "yes" vote on the nuclear weapons freeze resolution which will be on the Wisconsin ballot in September,

. . . congratulated the Wisconsin Legislature on its recent passage of the infant car seat law,

. . .favored the reenactment of the mandatory helmet law for motorcyclists,

. . .encouraged the promotion and use of seat belts and shoulder harnesses, and

. . . encouraged strict enforcement of the drunken driving laws and offered to cooperate in the enforcement of these laws.

The WAFP, organized in 1948, has a membership of just over 1,000 practicing family physicians. In addition, 187 physicians in Family Practice Residency Training Programs in Wisconsin also are members, as well as over 500 students in the state's two medical schools, who have indicated an interest in family medicine, and are classified as student affiliate members.

The executive secretary of WAFP is Robert H Herzog, with Academy headquarters at 850 Elm Grove Road, Elm Grove, Wisconsin 53122 (phone: 414/784-3656).

Wisconsin Surgical Society, at its Spring meeting, elected the following MDs as officers: Thomas J Beno,* Green Bay, president; Richard B Windsor,* Sheboygan, president-elect; and Gale L Mendeloff,* Milwaukee, secretary-treasurer. Eugene E Eckstam, MD,* Monroe and Johan A Mathison, MD,* Oshkosh, were elected to the council. New members elected to the Society are MDs Khosro Abid,* Madison; Muhammad Y Ahmad,* Merrill; Renato T Faylona,* Wisconsin Dells; Badri N Ganju,* Chilton; Lynn Koob,* Rice Lake; Robert H Mikkelsen,* Fond du Lac; and James V Seegers,* Elkhorn.

Wisconsin-Upper Michigan Society of Ophthalmology will hold its Annual Meeting in Marshfield on Saturday, September 18, with the scientific session at the Marshfield Clinic. Accommodations for participants will be available at the Holiday Inn, Marshfield. Six hours of Category 1 CME credit will be given.

Participating faculty includes: Richard G Chenoweth, MD, Chief, Department of Ophthalmology, Devers Eye Clinic and Good Samaritan Hospital & Medical Center, Portland, Oregon, whose topics will be "Management of Intraocular Foreign-Body Trauma with Vitrectomy" and "Vitrectomy for the Anterior Segment Surgeon;"

Melvin C Chen, MD,* Retina Service, Marshfield Clinic, "Epiretinal Membranes;" Suresh R Chandra, MD,* Retina Service, University of Wisconsin Hospital & Clinics, Madison, "Macula Photocoagulation Study Update;" William M Bourne, MD, Cornea Service, Mayo Clinic, Rochester, Minnesota, "New Techniques in Cornea Transplantation" and "Specular Microscopy, Fluorophotometry, and the ICE Syndrome;" and

Marilyn C Kay, MD, Neuroophthalmology Service, The Medical College of Wisconsin, Milwaukee, "Visual Cortex Dysfunction and the Visual Agnosias;" Ronald L Radius, MD, Glaucoma Service, The Medical College of Wisconsin, Milwaukee, "Laser Trabeculoplasty Update."

The meeting will be opened at 8:30 am by President Charles A Errico, MD,* Marshfield, who will give the welcoming address and preside during the day. After the meeting, the Annual Banquet will be held in the evening at the Casa Loma Supper Club in Marshfield.

Registration fee is $30 for members, $45 for nonmembers, and $15 for ophthalmology residents, and includes breaks and luncheon.

Further information regarding meeting registration or membership may be obtained by writing or calling Charles A Errico, MD, President, 913 West State Street, Marshfield, Wisconsin 54449 (715/387-5236); or Michael R McCormick, MD,* Secretary-Treasurer, 102 East Main Street, Waukesha, Wisconsin 53186 (414/547-3352).

Milwaukee Society of Head and Neck Medicine and Surgery, at a recent meeting, elected Paschal A Sciarra, MD,* Sheboygan, as its new president. Doctor Sciarra is a charter member of the Society which was established in 1975. He has been associated with the medical staff of the Sheboygan Clinic since 1958, and also is an associate clinical professor of otolaryngology at The Medical College of Wisconsin. Doctor Sciarra is on the medical staff of St Nicholas and Sheboygan Memorial hospitals and has served as president of the medical staff at St Nicholas, and currently is secretary-treasurer of Sheboygan Memorial Hospital. He is a graduate from the University of Cincinnati School of Medicine and served his residency at the Mayo Clinic, Rochester, Minn.■

Physician Briefs

*Physician members of State Medical Society of Wisconsin

P Stephen Schultz, MD,* La Crosse, recently was named medical director for Skemp-Grandview-La Crosse Clinic. He succeeds Robert L Gilbert, MD, who retired. Doctor Schultz has been a member of the clinic since 1976 and graduated from the University of Illinois Medical School. He completed his residency at the C S Mott Children's Hospital, University of Michigan, Ann Arbor. He also is medical director of the La Crosse Home for Children.

Cedric V Thayer, MD, Two Rivers, recently became associated with Doctors Clinic Ltd. Doctor Thayer graduated from the University of Wisconsin Medical School, Madison, and served two years in Vietnam before his residency training at Long Beach Veterans Administration Hospital. He also had one year of specialized training at the University of California-Irvine.

David Rutledge, MD and **Mark Hansen, MD,** Jefferson, recently began their medical practice in Jefferson and are associated with Fort Atkinson Memorial Hospital. Doctor Rutledge graduated from the Northwestern University School of Medicine, Evanston, Ill, and served his residency in family practice at the Rockford Medical Education Foundation. Doctor Hansen graduated from the Medical College of Wisconsin, Milwaukee, and also completed his residency in family practice at the Rockford Medical Education Foundation.

John Goetz, MD, Port Washington, recently joined the medical staff of Medical Associates of Ozaukee County. Doctor Goetz graduated from the Medical College of Wisconsin, Milwaukee, and completed his pediatric residency at the University of Missouri Medical Center in Columbia.

John G Beck, MD (seated left above), recently was presented with a plaque honoring 49 years of service to the community and the medical profession. Presentation was made by Tom Schueppert, MD* (seated right above), on behalf of the medical staff of Door County Memorial Hospital. Standing above are E B Mickelson, hospital administrator, and Doctor Beck's son, John J Beck, MD.* (Photo courtesy *Door County Advocate,* Sturgeon Bay)

Thomas F Garland, MD,* Elm Grove, associate professor of the Department of Family Practice at the Medical College of Wisconsin, recently was named chairman of the department. Since 1976, Doctor Garland has served as vice-chairman of the family practice department and director of the family practice residency program at Good Samaritan Medical Center-Deaconess Campus. He graduated from the University of Wisconsin Medical School, Madison, and served his residency training at Edward Sparrow Hospital in Lansing, Mich. He has been on the medical staff at Deaconess Hospital for 20 years.

Dr Garland

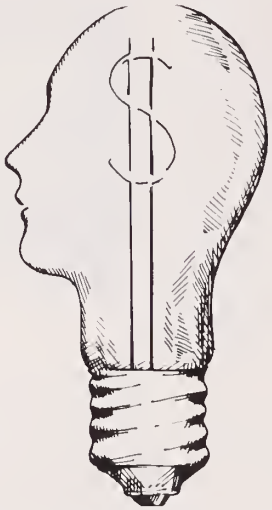
Thomas Templeton, MD, and **Nina Templeton, MD,** recently were appointed to the medical staff of Memorial Hospital, Manitowoc. Doctor Thomas Templeton is chairman of the Department of Anesthesiology and Doctor Nina Templeton will serve on the department's courtesy staff. Both physicians also will serve the Two Rivers Community Hospital. The physicians graduated from the University of Wisconsin Medical School, Madison, where they also served their internships. Their residencies were completed at the University of Wisconsin Hospitals and at Virginia Mason Hospital. Doctor Nina Templeton also served a fellowship at the University of Washington Affiliated Hospital, while Doctor Thomas Templeton served on the medical staff of Auburn General Hospital, Auburn, Wash.

Charles A Schmitt, MD, Sheboygan, has accepted an appointment in the Department of Anesthesiology at Sheboygan Memorial Hospital. Doctor Schmitt will join Marvin G Jumes, MD,* director of anesthesiology at Memorial since 1960. He graduated from the University of Wisconsin Medical School, Madison, and served his internship and residency at Michigan Medical Center, Ann Arbor.

James P Long, MD, Beloit, has joined the medical staff of Medical Associates of Beloit. Doctor Long graduated from the Universidad Autonama de Guadalajara Medical School in Mexico. He served his internship and residency at St Joseph's Medical Center in New York. Doctor Long was chief resident in family practice at St Joseph's Medical Center.

Beth L Foster, MD,* Milwaukee, and **Sally Hunt, MD,** Milwaukee, recently have purchased the pediatric practice of Donald J Cohen, MD,* in Fox Point. Doctor Foster graduated from The Medical College of Wisconsin and Doctor Hunt graduated from Universite Libre de Bruxelles in Brussels, Belgium. They completed their residencies at The Medical College of Wisconsin and Milwaukee Children's Hospital. Doctor Foster is a member of the faculty of The Medical College of Wisconsin and also is on the medical staff at Curative Rehabilitation Center.

Dollars Sense.



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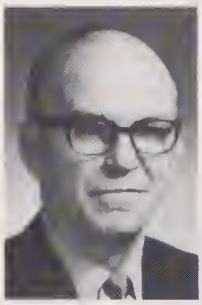
L Maramon Pippin, MD,* Richland Center physician for 36 years, recently retired from his medical practice. Doctor Pippin came to Richland Center in 1946 after serving with the United States Army for two years. Doctor Pippin graduated from the University of Louisville School of Medicine and served his residency at Louisville General Hospital, Kentucky.

John L Claude, MD, Oconomowoc, has returned to his medical practice at the Wilkinson Clinic. He recently completed a tour of duty as chief of the obstetrics-gynecology service at the United States Army Hospital in Augsburg, Germany. He had been affiliated with the Clinic since 1955.

Ram Das, MD, Beloit, recently joined the medical staff at the Beloit Clinic to start a new department, Occupational Medicine, which serves the Greater Beloit business community. Doctor Das has been the director of Emergency Room physicians at Beloit Memorial Hospital for the past three and one-half years.

Todd Swanson, MD, Eau Claire, recently became a member of the medical staff of the Eau Claire Group Health Cooperative. Doctor Swanson graduated from the University of Wisconsin Medical School, Madison, and completed his family practice residency at the Eau Claire Family Practice Clinic.

Herman C Schmallenberg, MD,* New London physician since 1934, recently was honored by the community at a "Dr Schmallenberg Day" testimonial. He graduated from the University of Wisconsin Medical School, Madison, and served an internship at Milwaukee County Hospital. Active in community affairs, Doctor Schmallenberg also is a past president and has served as chief-of-staff of the New London Hospital. This year at the State Medical Society's Annual Meeting, Doctor Schmallenberg was inducted in the "50 Year Club" of the Society. He is continuing his medical practice in New London on a reduced schedule.



Dr Schmallenberg

Ann Rock, MD, recently became associated with the East End Clinic LTD in Superior. Doctor Rock graduated from the University of Wisconsin Medical School, Madison, and served an internship at Maricopia County General Hospital, Phoenix, Ariz. She practiced in Ashland for one year and then served a residency in the Department of Obstetrics and Gynecology at the University of Miami Affiliated Hospitals and Jackson Memorial Hospital, Miami, Fla.

James Schumaker, MD, Black River Falls, recently became associated with the medical staff of the Krohn Clinic and the Black River Memorial Hospital. Doctor Schumaker graduated from the University of Wisconsin Medical School, Madison, and served residencies at Boise, Idaho, and Modesto, California. Following residency, Doctor Schumaker accepted a volunteer position at St Jude's Hospital in St Lucia, West Indies.

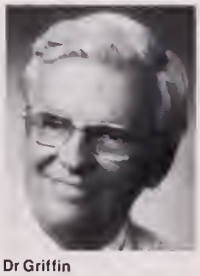
Donald T Rendel, MD, recently joined the medical staff of Eagle River Memorial Hospital. Doctor Rendel graduated from the Indiana University School of Medicine and served his residency, in pediatrics, at Children's Memorial Hospital in Chicago. Prior to joining the Eagle River Memorial Hospital medical staff, he had been associated with the St Margaret Hospital, Hammond, Ind, where he also was in private practice.

Dr Nichol

Kathryn P Nichol, MD,* Madison, recently was named "Pediatrician of the Year" by the Wisconsin Chapter of the American Academy of Pediatrics. She was cited for her work in developing infant and toddler car seat programs throughout the state. Doctor Nichol is state chairman of the Academy's "The First Ride a Safe Ride" program, which promotes the use of approved car seats when infants are taken home from the hospital. She graduated from the University of Wisconsin Medical School, Madison, and has been affiliated with the Dean Clinic since 1970.

William T Mautz, MD,* Eau Claire, recently retired as assistant director of health services at the University of Wisconsin-Eau Claire. Doctor Mautz joined the University staff in 1966 on a part-time basis, and in 1971 he gave up private practice to become director and full-time physician of Health Services. In 1980, Doctor Mautz retired as director to become assistant director. He was succeeded as director by Charles Bass, MD. Doctor Mautz also is past president of Eau Claire-Dunn-Pepin County Medical Society and past president of the Eau Claire City-County Health Department.

Vernon M Griffin, MD,* Mauston area physician for 36 years, recently retired from medical practice. He was honored at a testimonial banquet that was attended by many of his friends and former patients. He began his medical practice in Mauston 36 years ago and played a major part in initiating the construction of the addition to Hess Memorial Hospital in 1963. As president of the Hospital Association he helped to finalize plans for the new hospital and nursing home facilities. Active in the State Medical Society of Wisconsin, Doctor Griffin recently was elected vice-speaker of the House of Delegates. He had served on the Reference Committee on Credentials; was a member of the Nominating Committee of the SMS House of Delegates; and has served as a delegate from Juneau County since 1950. ■



Dr Griffin

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News Highlights

*Physician members of State Medical Society of Wisconsin

Kenosha Memorial Hospital recently named Marily Zuba as director of human resources. She has been personnel manager at the hospital since 1979. Prior to joining Kenosha Memorial, Ms Zuba was employment coordinator for Methodist Hospital in Madison. She serves as post advisor to the Kenosha Memorial Hospital Explorers Post and is a member of the American Association of University Women. She also is a member of the Healthcare Personnel Administrators of Wisconsin.

American Cancer Society/Wisconsin Division has named Ms Sandy Balmer as an area executive director. Ms Balmer will coordinate the programs and activities of the volunteers in a three-county area encompassing Racine, Kenosha, and Walworth counties. Ms Balmer graduated from the University of Wisconsin-La Crosse.

Wautoma Memorial Hospital recently elected Edward H Glazier, MD,* Waupaca, chief-of-staff. Also elected were MDs William G Richards,* vice-president, and Thomas F Winters, secretary. Other members of the active medical staff include MDs J T Grosshans, Dennis G Greer,* and Barry L Rogers.*

Sacred Heart Hospital, Eau Claire, recently named the following MDs as officers and department chairmen for one year. They are Charles R Nordstrom,* president; David J Katz,* vice-president; Mark H Attermeier, secretary-treasurer; Dale L Reid,* family medicine; and Robert E Davidson,* psychiatry and neurology. Other chairmen reelected to their positions are Terrence R Borman,* medicine; Robert J Fink,* pathology; Kim P Stien, radiology; and Roy A Olson,* surgery.

Marshfield Clinic's Ladysmith, Stanley, and Greenwood regional medical centers' administrator, Duane David, recently was named assistant director of regional centers. Mr David will be responsible for overseeing day-to-day operations of the Clinic's six satellite facilities located in Stratford, Mosinee and Wautoma, in addition to Ladysmith, Stanley and Greenwood. He joined the Clinic staff as administrator of Ladysmith Center in 1979 and earned his Masters Degree in Business Administration at the University of Northern Colorado in Greeley.

St Michael Hospital, Milwaukee, recently elected new officers of its medical staff. They are MDs Daniel J Price,* Fox Point, president; Kuang S Kim,* Mequon, vice president/parliamentarian; Joseph L Teresi,* Brookfield, secretary-treasurer; Marvin Wagner, Fox Point, past president; Beryl A Harris,* River Hills, chairman, Dept of Pediatrics; Isidro L Maranan,* Glendale, representative, Ancillary Services; William R Mills, Menomonee Falls, chairman, Dept of Family Practice; Andrew A Pandazi,* Whitefish Bay, chairman, Dept of Surgery; Alvin J Schachter, Mequon, chairman, Dept of Internal Medicine; William L Semler,* Whitefish Bay, chairman, Dept of Ob/Gyn; Herman Tuchman,* Fox Point, member-at-large; Albert S Yee, Bayside, Director of Emergency Medicine; and Clifford L Zeller,* chairman, Dept of Psychiatry. Doctor Price was elected to a two-year term and the other members of the executive committee for a one-year term. ■

Socioeconomic Monitoring System. The AMA has launched a speedier method of gathering and reporting changes in many aspects of physicians' practices. The system substitutes periodic telephone interviews with randomly selected physicians for annual mail questionnaires, the principal device used to gather socioeconomic information since 1966. The new system will yield information in about ten weeks instead of the 12 months required to gather and analyze mail survey forms. It will provide the AMA with the capability to update socioeconomic data on quarterly basis. Survey results will be widely disseminated. The program is directed by the AMA Center for Health Policy Research in cooperation with the AMA Division of Survey and Data Resources. Mathematica Policy Research, Inc of Princeton, NJ, will conduct the telephone interviews for the AMA. ■

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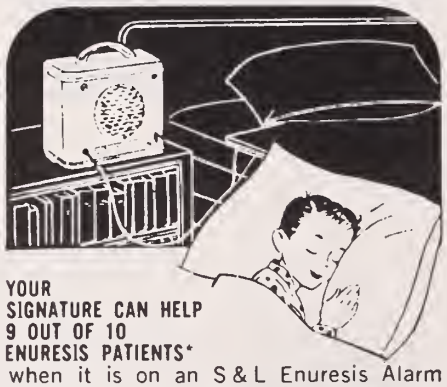

YOUR SIGNATURE CAN HELP 9 OUT OF 10 ENURESIS PATIENTS*
when it is on an S & L Enuresis Alarm prescription form. We furnish the forms—and assure you that S & L Enuresis Alarms are available **on prescription only.** We rent the alarm to your patient. It is used at home under your supervision. The cost is low—$10.00 per week.
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There's more to ZYLOPRIM® than (allopurinol).

- From Burroughs Wellcome Co. – the discoverer and developer of allopurinol
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Prescribe for your patients as you would for yourself.

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ONE OF THE VITAL SIGNS OF ANXIOUS DEPRESSION:

INSOMNIA

Others to look for:

agitation
anorexia
feelings of guilt and worthlessness
fatigue
palpitations
headache
vague aches and pains
sadness
psychic and somatic anxiety

Artist's conception, looking out from the human eye as conceived in a schematic model.

ROCHE

LIMBITROL GIVEN H.S.: ONE OF THE VITAL SPECIFICS OF TREATMENT

Limbitrol brings a special—and specific—quality of relief to most anxious depressed patients. Insomnia, for example, responds with particular promptness. Other symptoms likely to respond within the first week of treatment include anorexia, agitation and psychic and somatic anxiety. And, as the depression and anxiety are alleviated, in many cases so are such related somatic symptoms as headache, palpitations, and various vague aches and pains.

Limbitrol given once daily h.s. may be the best approach

Many patients respond readily to a single bedtime dose of Limbitrol, a convenient schedule that may enhance compliance and helps relieve the insomnia associated with anxious depression. Limbitrol also offers a choice of other regimens: t.i.d., or a divided dose with the larger portion h.s. In all cases, caution patients about the combined effects with alcohol or other CNS depressants and about activities requiring complete mental alertness, such as driving or operating machinery.

in moderate depression and anxiety

Limbitrol® IV

Tablets 5-12.5 each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)
Tablets 10-25 each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt)

Specific therapy with h.s. dosage convenience

Please see summary of complete product information on following page.

LIMBITROL® TABLETS Tranquilizer—Antidepressant
Before prescribing, pleose consult complete product informotion, o summory of which follows:
Indicotions: Relief of moderate to severe depression associated with moderate to severe anxiety
Controindicotions: Known hypersensitivity to benzodiazepines or tricyclic antidepressants Do not use with monoomine oxidose (MAO) inhibitors or within 14 days following discontinuotion of MAO inhibitors since hyperpyretic crises, severe convulsions and deoths have occurred with concomitont use, then initiote cautiously gradually increasing dosoge until optimol response is achieved Controindicated during acute recovery phose following myocordiol infarction
Wornings: Use with great core in potients with history of urinory retention or ongle-closure glaucomo Severe constipotion may occur in potients toking tricyclic antidepressants and onticholinergic-type drugs Closely supervise cordiovoscular potients (Arrhythmios, sinus tochycordio and prolongotion of conduction time reported with use of tricyclic antidepressants, especially high doses Myocordiol infarction and stroke reported with use of this closs of drugs) Coution potients obout possible combined effects with olcohol and other CNS depressants and against hozardous occupotions requiring complete mentol olertness (e g , operoting mochinery, driving)

***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should olmost olways be avoided because of increased risk of congenital molformotions os suggested in several studies. Consider possibility of pregnoncy when instituting therapy; odvise potients to discuss theropy if they intend to or do become pregnont.**

Since physicol and psychologicol dependence to chlordiozepoxide hove been reported rorely, use coution in odministering Limbitrol to oddiction-prone individuols or those who might increose dosoge, withdrowol symptoms following discontinuotion of either component olone hove been reported (nouseo, heodoche ond moloise for omitriptyline, symptoms [including convulsions] similor to those of borbiturote withdrowol for chlordiozepoxide)
Precoutions: Use with coution in potients with o history of seizures, in hyperthyroid potients or those on thyroid medicotion, ond in potients with impoired renol or hepotic function Because of the possibility of suicide in depressed potients, do not permit eosy occess to lorge quontities in these potients Periodic liver function tests ond blood counts ore recommended during prolonged treotment Amitriptyline component may block oction of guonethidine or similor ontihypertensives Concomitont use with other psychotropic drugs hos not been evoluoted: sedotive effects may be odditive Discontinue several doys before surgery Limit concomitont odministrotion ot ECT to essentiol treotment See Wornings for precoutions obout pregnoncy Limbitrol should not be token during the nursing period Not recommended in children under 12 In the elderly ond debilitoted, limit to smollest effective dosoge to preclude otoxio, oversedotion, confusion or onticholinergic effects
Adverse Reoctions: Most frequently reported ore those ossocioted with either component olone drowsiness, dry mouth, constipotion, blurred vision, dizziness ond blooting Less frequently occurring reoctions include vivid dreoms, impotence, tremor, confusion ond nosol congestion Many depressive symptoms including onorexio, fotigue, weokness, restlessness ond lethorgy hove been reported os side effects of both Limbitrol ond omitriptyline Gronulocytopenio, joundice ond hepotic dysfunction hove been observed rorely
The following list includes odverse reoctions not reported with Limbitrol but requiring considerotion because they hove been reported with one or both components or closely related drugs
Cordiovoscular Hypotension, hypertension, tochycordio, polpitotions, myocordiol infarction, orrhythmios, heort block, stroke
Psychiotric Euphorio, opprehension, poor concentrotion, delusions, hollucinotions, hypomonio ond increosed or decreosed libido
Neurologic Incoordinotion, otoxio, numbness, tingling ond poresthesios of the extremities, extropyromidol symptoms, syncope, changes in EEG potterns
Anticholinergic Disturbonce of occommodotion, porolytic ileus, urinory retention, dilototion of urinory tract.
Allergic Skin rosh, urticorio, photosensitizotion, edemo of foce ond tongue, pruritus
Hematologic Bone morrow depression including ogronulocytosis, eosinophilio, purpuro, thrombocytopenio
Gastrointestinal Nouseo, epigostric distress, vomiting, onorexio, stomotitis, peculior toste, diorrheo, block tongue
Endocrine Testicular swelling ond gynecomostio in the mole, breost enlorgement, golocторrheo ond minor menstrual irregulorities in the femole ond elevotion ond lowering of blood sugor levels
Other Heodoche, weight goin or loss, increosed perspirotion, urinory frequency, mydriosis, joundice, olopecio, porotid swelling
Overdosoge: Immediotely hospitolize potient suspected of having token on overdose Treotment is symptomotic ond supportive IV odministrotion of 1 to 3 mg physostigmine solicylote hos been reported to reverse the symptoms of omitriptyline poisoning See complete product informotion for monifestotion ond treotment
Dosoge: Individuolize according to symptom severity ond potient response Reduce to smollest effective dosoge when sotisfoctory response is obtoined Lorger portion of doily dose moy be token ot bedtime Single *h.s.* dose moy suffice for some potients Lower dosoges ore recommended for the elderly Limbitrol 10-25, initiol dosoge of three to four tobles doily in divided doses, increosed to six tobles or decreosed to two tobles doily os required Limbitrol 5-12 5, initiol dosoge of three to four tobles doily in divided doses, for potients who do not tolerote higher doses
How Supplied: White, film-cooted tobles, eoch containing 10 mg chlordiozepoxide ond 25 mg omitriptyline (os the hydrochloride solt) ond blue, film-cooted tobles, eoch containing 5 mg chlordiozepoxide ond 12 5 mg omitriptyline (os the hydrochloride solt)—bottles of 100 ond 500, Tel-E-Dose® packoges of 100, ovoilable in trays of 4 reverse-numbered boxes of 25, ond in boxes containing 10 strips of 10, Prescription Poks of 50

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Medical Yellow Pages

RATES: 40¢ per word, with a minimum charge of $16.00 per ad. BOXED AD RATES: $32.00 per column inch. DEADLINE: Copy must be received by the 20th of the month preceding month of issue; e.g., copy for the August issue is due July 20. Send copy to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 800/362-9080.

Physicians Exchange

Position Opportunities—Satellite Expansion. Expanding from an existing complement of forty-five practitioners, Southeastern Wisconsin's premier multispecialty clinic will soon be establishing a satellite location approximately fifteen to twenty miles from the main Clinic facility in the heart of a group of communities that has long utilized our physicians and services for their medical care. We currently serve over 40% of the county in which this facility will be located. These opportunities are immediately available; we anticipate starting operations in our statellite location no later than July 1983 (and sooner should our staffing allow it). We offer a competitive first-year starting salary plus further incentive compensation based upon productivity. Corporately provided benefits include malpractice, health, life and group and individual disability insurances; vacation and meeting time allowances; etc. We are prepared to consider applications from *general internists, family practitioners,* and *pediatricians.* To learn more about our opportunities, to receive a copy of our physician recruiting brochure, and to receive our immediate consideration, please submit your CV to Mr Robert P Thompson, Administrator, Milwaukee Medical Clinic, SC, 3003 West Good Hope Rd, PO Box 17300, Milwaukee, Wis 53217. 8-9/82

Family Physician to join three Board certified family physicians in a young and growing medical practice in Central Minnesota. The practice is orientated toward Family Practice Medicine and located centrally in the state with quick access to the Minneapolis-St Paul area. Both practices are a short distance from the St Cloud area, and our physicians use the St Cloud Hospital for hospitalization of their patients. Cultural and recreational activities are abundant in this area of Minnesota. The salary and fringe benefits are open and negotiable. If interested, please contact Thomas J Newton, MD, Medical Director, or contact Daryl G Mathews, Administrator, at either the St Joseph or Cold Spring Medical Clinics, 26 North Red River Ave, Cold Spring, Minnesota 56320; or call collect (612) 685-8641 or (612) 363-7765 in St Joseph, Minnesota. 7-10/82

Anesthesiologist, Wisconsin-born. Graduate University of Wisconsin Medical School, 1980. Currently training in New England desires practice in Wisconsin. Trained in all types of anesthesia. Available August 1983. Contact Dept 506 in care of the Journal. 8-10/82

PUT EXPERIENCE TO WORK FOR YOU WHILE YOU SEARCH FOR A NEW CHALLENGE

Let years of experience as a healthcare professional and a Placement Counselor assist you in finding a new location with a new challenge. Physicians in all specialties are urgently needed throughout the country. Many types of situations available. Confidentiality assured.

Contact Donna Herschleb, RN
MEDICAL PROFESSIONAL PLACEMENTS
5222 Painted Post Drive, Madison, Wisconsin 53716
Phone: (608) 222-2927 *Licensed Employment Agency*

Position available—MD Emergency Medicine. Madison area hospital has position available in its Emergency Room. Responsibilities include clinical coverage and complete care in the Emergency Department and follow-up of patient care in other areas of hospital. Additional duties include meetings and activities as required including serving as liaison with paramedic, nursing staff, and other healthcare providers and being a member of various committees. Applicant must have 3 years experience, including having been a 3rd year resident in emergency medicine and a graduate of an approved residency program in emergency medicine. Candidate must be Board eligible in emergency medicine and licensed in State of Wisconsin. Position entails 40 hours per week, no overtime, with a salary of $72,000. Qualified applicants should contact Mr Sath Menon, Wisconsin Job Service Office, 206 N Broom St, Madison, Wis 53703; ph 608/266-2341. 8/82

Ideal practice opportunities for Family Practice and Internal Medicine in scenic Kettle Moraine area, Plymouth, Wisconsin. Less than one hour drive from Milwaukee, 60 miles from Green Bay. Service community of 20,000. Modern JCAH hospital and 60-bed nursing home. Family-oriented community with good industrial base. Please contact: Peter R Strub, Coordinator, Physician Recruitment Committee, Plymouth Hospital, Inc, 901 Reed St, Plymouth, Wis 53703; ph 414/803-1771. 8/82*

Milwaukee, Wisconsin Opportunity. Expanding from an existing complement of forty-five practitioners, Southeastern Wisconsin's premier multispecialty clinic seeks a practitioner (family practice, industrial medicine, or general internal medicine) to direct the activities of our newly established Urgent Care Center. We offer a competitive first year starting salary plus further incentive compensation based upon productivity. Corporately provided benefits include malpractice, health, life, and group and individual disability insurances; vacation and meeting time allowances; etc. To learn more about our opportunity, to receive a copy of our physician recruiting brochure, and to receive our immediate consideration, please submit your CV to Mr Robert P Thompson, Administrator, Milwaukee Medical Clinic, SC, 3003 West Good Hope Road, PO Box 17300, Milwaukee, Wisconsin 53217. 8-9/82

Pediatric, Family Practice positions available in 13-member multispecialty group. Inquire: General Clinic of West Bend, Inc, 279 S 17th Ave, West Bend, Wis 53095. 2tfn/82

PRIMARY CARE PHYSICIANS
BOARD CERTIFIED OR ELIGIBLE

We represent over 50 communities throughout the state which are seeking quality primary care physicians. These communities offer established service areas, generous practice and financial arrangements.

CONTACT:
Laurie Glowac or Fred Moskol
New Physicians for Wisconsin
University of Wisconsin Department of Family Medicine
777 South Mills Street, Madison, Wisconsin 53715
Phone: 608/263-4095

1-12/82

Physicians Exchange

continued

Doctors needed—in Wisconsin. All specialties and all locations. For confidential information, mail your CV to: Medicus, 1525 Wisconsin Ave, Grafton, WI 53024. 6tfn/82

Wausau Medical Center, SC, a 50-physician multispecialty group has openings for physicians in the following specialties: *Neurology, Otolaryngology, Cardiology* and *General Surgery* with a fellowship training in *Peripheral Vascular Surgery.* Competitive first-year salary, incentive plan thereafter. Comprehensive fringe benefits. New facility near new hospital. Located in beautiful, quiet, central Wisconsin, metropolitan area of 65,000. Recreational opportunities abundant. For more information contact: K L Day, MD, Wausau Medical Center, SC, 2727 Plaza Drive, Wausau, Wis 54401, or call collect 715/847-3351. 6tfn/82

General Surgeon. Enjoy the security of group practice with the freedom of independent practice. If you are a Board certified or Board eligible general surgeon, we have an interesting opportunity for you. A general surgeon is needed immediately to form an independent practice in a very desirable Northern Wisconsin community with a drawing population of 100,000. All major specialists available for consultation. A growing community hospital with 240-beds with excellent medical and surgical subspecialty representation. Opportunities for endoscopy and peripheral vascular surgery also exist. For further information write: Administrator, PO Box 1646, Wausau, Wis 54401. 7-9/82

Family Practice Physician to share fully equipped medical office in central Wisconsin city. Opportunity for partnership and eventual purchase of practice. Excellent recreational, educational, hospital, and civic advantages. Send curriculum vitae to Dept 503 in care of the Journal. 6tfn/82

Family Physician to join our group of six Board certified family practitioners and Board certified general surgeon. Liberal vacation and educational allowances. Competitive salary first year with incentive bonus, and full membership after one year. Blue Earth is a farming town of 4000 in Southern Minnesota with a drawing area of 25,000. 35-bed hospital with adjoining clinic facilities. Complete opportunity for an aggressive young family physician. Please contact Marjeane Werner or Thomas E Watts, MD, Blue Earth Medical Center, Ltd, 520 South Galbraith, Blue Earth, Minn 56013; ph 507/526-7371. 8-12/82; 1/83

Obstetrics·Gynecology position available with an 18-member multispecialty group corporate practice. Modern clinic facility in Northeastern Wisconsin city of 100,000 enjoying a health and stable economy. Excellent recreational, educational, hospital, civic advantages. Please write: W J Mommaerts, Clinic Manager, West Side Clinic, SC, 1551 Dousman St, Green Bay, WI 54303. 6-9/82

Family Practitioners with option to join two-man group, or establish a group of their own. Ideal medical office facility; 60-bed accredited full service hospital which accomodates family practitioners. Located in the heart of paper making industry, Northeastern Wisconsin. Interested physicians write or call collect, Roger M Anderson, Kaukauna Community Hospital, 308 East 14th St, Kaukauna, WI 54130; tel 414/766-4211. 6-8/82

NATIONWIDE PHYSICIAN PLACEMENTS

We are seeking physicians on behalf of clients in various parts of the country. Opportunities exist in many specialties. For information call Steve Hymes (collect) at 608/271-8811.

Horner Medical Placements, 5721 Odana Rd. Madison, WI 53719 *A licensed employment agency*

Board eligible/Certified FP's needed at multiple locations in Northeastern rural Wisconsin. Financial assistance available and negotiable. Excellent locations, communities, recreation areas. Contact J Schumacher, Administrator, Calumet Memorial Hospital, Chilton, Wis 53014; ph 414/849-2386. 7-9/82

Family Practice, Sparta Clinic, Ltd, Sparta, Wis, a six physician group offers an excellent opportunity for a family physician willing to do some obstetrics. The Clinic is located one block from St Mary's Hospital and 25 miles from a major referral center. Salary guarantee available plus potential for bonus based on work done. Clinic pays all insurance and pension and profit sharing after one year. MD or DO. Contact Thomas E Flood, Administrator, Sparta Clinic, Ltd, PO Box 250, Sparta, Wis 54656; ph 608/269-6731. 7-9/82

Family Practice/Urgent Care position immediately available in a 42-member multispecialty group corporate practice to direct and operate evening and weekend Urgent Care facility. Beautiful clinical facility in Glendale, Wisconsin, a northern Milwaukee suburban city. Guaranteed first-year salary, stockholdership and partnership after one year, plus profit-sharing. To learn more about our opportunity and to receive our immediate consideration, please submit your CV to Mr James A Heinz, Assistant Administrator, Milwaukee Medical Clinic, SC, 3003 West Good Hope Rd, PO Box 17300, Milwaukee, Wis 53217. 8-10/82

Obstetrician/Gynecologist to join well established general surgeon. Coverage available. Malpractice and other expenses paid. No initial expenses. Clinic one block from hospital. Excellent hunting, fishing and skiing within 4 mile area. Initial salary. Later option to join and buy in corporation. Position available immediately. Wisconsin license required. Contact Dept 505 in care of the Journal. 8/82

The Racine Medical Clinic, a progressive cluster corporation of 25 physicians, is currently seeking an orthopedic surgeon and an invasive cardiologist. Full benefits, unlimited earnings and a full and exciting practice are offered. Please contact: Roger D Lacock, Administrator, Racine Medical Clinic, 5625 Washington Ave, Racine, WI 53406; ph 414/886-5000. 1tfn/82

Dermatologist, Family Practitioner needed to join multispecialty group of 33 physicians dedicated to primary care in East Central Wisconsin community. City population 48,000, drawing area 100,000. Attractive income arrangements, association membership possible after one year, pension and profit sharing, extensive fringe benefits. Contact R B Windsor, MD, 1011 North 8th St, Sheboygan, Wis 53081; ph 414/457-4461. 5tfn/82

Adult Psychiatrist to join well established group in a community of 50,000 with large referral area. Two excellent hospitals, University, and industrial area. Salary—open. Excellent benefits. For further information contact: J M Tobin, MD, Northwest Psychiatric Clinic, Eau Claire, Wis 54702; ph 715/834-2751. 8-12/82; 1/83

Surgeon with Thoracic general vascular training, Ophthalmologist, and ENT, to join a progressive multispecialty group of 17 physicians consisting of General/Family Medicine, General Surgery, Internal Medicine, OB-GYN, Ophthalmology, Orthopaedic Surgeon, Pediatrics/Adolescent Medicine, and Radiology. Subspecialties include: Pathology, Vascular Surgery, Cardiovascular Diseases, Gastroenterology and Endoscopy. We are located in a fast growing, scenic, lake country area between Milwaukee and Madison and can offer excellent hospital, schools, and recreational facilities. Full fringe benefit package. Contact: James F Dowd, Admin, Wilkinson Clinic SC, 915 East Summit Ave, Oconomowoc, Wis 53066; ph 414/567-4433. 9tfn/81

Family Physician or Internist to join three-man family and general practice group in the heart of North Central Wisconsin vacationland. First year guaranteed salary. Numerous fringe benefits. Clinic across from hospital. Send CV to: O M Francisco, MD, 221 E Washington Ave, Tomahawk, Wis 54487; ph 715/453-2147. 5tfn/82

Wanted. Board certified or eligible orthopedic surgeon to practice in conjunction with a 5-member surgery department in a 22-member multispecialty group. Present surgical specialties: thoracic and vascular surgery, general surgery and urology. The group is located in the upper midwest, in a city of 100,000 between two major metropolitan areas of greater than one million. If interested, please send CV to: Stephen Wagner, Kurten Medical Group, SC, 2405 Northwestern Ave, Racine, Wis 53404. All inquiries will be kept confidential. 12tfn/80

Family Practice position available with an 18-member multispecialty group corporate practice. Modern clinic facility in Northeastern Wisconsin city of 100,000 enjoying a healthy and stable economy. Excellent recreational, educational, hospital, civic advantages. Please call collect or write: W J Mommaerts, Clinic Manager, West Side Clinic, SC, 1551 Dousman St, Green Bay, Wis 54303; ph 414/494-5611. 8-11/82

Internist wanted. Board certified or eligible with/without subspecialty, to practice in conjunction with a 6-member Internal Medicine Department in a 22-member multispecialty group. Present subspecialties: Gastroenterology and cardiology. The group is in Southeastern Wisconsin, in a city of 100,000 between two major metropolitan areas of greater than one million. If interested, please send CV to: Stephen L Wagner, Kurten Medical Group, 2405 Northwestern Ave, Racine, Wis 53404. All inquiries will be kept confidential. 3tfn/82

Family Practice Physician/or Primary Care Oriented Internist to join two family practice physicians and a Board certified surgeon in a group practice. Located in a community of 2,500 in southwest Minnesota. This medical clinic is supported by a modern 30-bed acute care hospital and 138-bed skilled long-term care facility. Guaranteed first year income, will pay travel expenses for interview. Interested physicians send curriculum vitae to William Wilson, Administrator, Springfield Community Hospital, PO Box 146, Springfield, Minn 56087 or call collect 507/723-4215 for more information. 5-10/82

Family Practice opportunity available to join a long established, four-physician family practice group in south central Wisconsin. Salary basis initially, leading to full corporate membership. Numerous fringe benefits. Pleasant community. Contact: Chad Burchardt, Business Manager, Medical Associates of Beaver Dam, SC, 1200 N Center St, Beaver Dam, Wis 53916; ph 414/887-7101. 8/82

Family physician, Board Certified or Eligible, to join four-man family practice group in northwest Wisconsin. First-year guaranteed salary. New clinic building located adjacent to 46-bed hospital, in the heart of Wisconsin's vacationland. Call shared with other family practice physicians in area, weekend coverage contracted. Jeanne Chamberlain, Adm, Spooner Clinic Ltd, 707 Ash St, Spooner, Wis 54801. Ph 715/635-2151. 7-10/82

Medical Facilities

Immediate solo practice available in Jefferson, Wisconsin, due to the recent death of Richard H Siedenburg, MD. Expandable building with three large lots available. Lease or purchase. Contact Miller Law Office, PO Box 417, Jefferson, Wisconsin 53549; ph 414/674-3345. g11tfn/81

Milwaukee. Busy family medical center for sale. Will introduce. Good for teaching interns and residents in Family Practice. Contact: R Gonzalez, MD; ph 414/344-1120 or 414/476-8624. 3-8/82

For Sale: Ritter motorized exam table, 3 exam tables, EKG, 5 surgical lights, medical refrigerator, sterilizer, magnifying eye light, 3 floor blood pressure machines, 2 surgical instrument stands, 2 x-ray view boxes, dryer, many other small items. Physician retired. Good condition, very reasonable. 521-8th St, So, Wisconsin Rapids, Wis 54494; ph 715/423-3500. 8-10/82

For Sale: Portable Burdick EKG with cart. Bio-refrigerator; sterilizer; portable electric typewriter; centrifuges (2); stainless disposal cans; 3-M dry photocopier; infant scale; small instruments; incidental lab equipment. Contact 1/414-769-9697 evenings. All excellent condition. Should be seen. 6/82*

Medical office space for lease. New Swiss chalet style building in fast growing community. Needs family practitioner, pediatrician, etc. Building has dentist and pharmacy. Very reasonably priced in Waukesha County near expressway. Info: call 414/781-1155. 7tfn/82

Medical equipment for sale, including a Craig x-ray unit, perfectly suited for a physician's office, and laboratory, ECG and exam room furnishings and equipment, plus office, lounge, and waiting room furniture, all in like-new condition. Call Administrator, 414/271-6800 for specific information. 8-9/82

Established medical practice for sale in San Francisco Bay area. Opportunity for internist or family practitioner. Growing community of 45,000. Excellent community hospitals. No internist in town, other specialties represented. Retiring MD will introduce. Send replies to: Joseph H Libbey Jr, MD, 150 Beede Way, Antioch, California 94509. p8/82

FOR SALE: Burroughs L-3000 minicomputer posting machine. Excellent condition, used only three years. Contact Associated Physicians, Fond du Lac, Wisconsin: 414/922-3700. 8-9/82

FOR SALE: E Leitz Wetzlar oil immersion microscope with case and glass cover. Manufactured 1912-1914. Asking $650. Phone 414/321-1549. 3565 S 75th St, Milwaukee. 8/82

Miscellaneous

Physicians Signature Loans to $50,000. Up to 7 years to repay. No prepayment penalties. Prompt, courteous service. Physicians Service Assn, Atlanta, GA. Toll-Free (800) 241/6905. 4tfn/82*

36% per year proven consistent returns with low-risk and low-tax rates. Contact Stan Tamulevich, independent registered Commodity Trading Advisor, at 608/833-8708 (Madison) for complete record and disclosure document. References available. Speaking engagements accepted. p8/82

Real Estate

A SAFE TAX SHELTER. Land ownership offers more. The new A.C.R.S. (Accelerated Cost Recovery System). Depreciation + Inflationary Appreciation + Investment Credits, all put money into your pocket. FAITH REALTY—Est 1960, Farm Specialist-Tax Consultant, Whitewater, Wis 53190 (414/473-2779). PS: Who do you know who wants to buy a farm? p3-8/82

Meetings/CME Courses

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates: 40¢ per word, with a minimum charge of $16.00 per listing. BOXED LISTINGS: $32.00 per column inch. COPY DEADLINE for Continuing Medical Education listings is tenth of the month preceding the month of publication; e.g., copy for the August issue is due by July 10. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 800/362-9080. For listing of other meetings see the Special issue of the Journal of the American Medical Association: Continuing Education Courses for Physicians for period Sept 1, 1981 through Aug 31, 1982.

WISCONSIN

SEPTEMBER 9, 1982: *Delivery of Health Care Services to Indochinese Refugees,* Wisconsin Center, Madison. Sponsored by University of Wisconsin-Extension, Dept of Continuing Medical Education, Wisconsin Dept of Health and Social Services, Division of Health, Bureau of Community Health and Prevention, Refugee Program; and University of Wisconsin School of Medicine. Elective 6 hours of AMA, AOA, AAFP. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, WI 53706; ph 608/263-2856.

SEPTEMBER 10-11, 1982: Wisconsin Surgical Society, La Crosse Lutheran Hospital, La Crosse.

SEPTEMBER 9-11, 1982: *Wisconsin Society of Internal Medicine and American College of Physicians* joint meeting, Holiday Inn Downtown, Green Bay. Info: Kim Marggraf, Wisconsin Society of Internal Medicine, 611 East Wells St, Milwaukee, Wis 53202 (414) 276-6445.

SEPTEMBER 9-12, 1982: Wisconsin Society of Anesthesiologists, Concourse Hotel, Madison.

SEPTEMBER 16, 1982: *Infection Control for Community Hospitals,* University of Wisconsin Clinical Science Center, Madison. Sponsored by University of Wisconsin-Extension, Continuing Medical Education; and University of Wisconsin School of Medicine, Dept of Medicine, Infection Control Unit. Approved AMA Category 1, AAFP, AOA, University Contiing Education Hours. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, WI 53706; ph 608/263-2856.

SEPTEMBER 16-17, 1982: *Current Concepts in Nutrition Support,* Holiday Inn, Eau Claire. Sponsored by Nutrition Support Services of Eau Claire. Approved 13 hours AMA Category I and AAFP prescribed hours. Info: Darlene Holtorf, Luther Hospital, 1221 Whipple St, Eau Claire, Wis 54701; ph 715/839-3512.

SEPTEMBER 17-19, 1982: Wisconsin Neurological Society, American Club, Kohler.

SEPTEMBER 18, 1982: Wisconsin-Upper Michigan Society of Ophthalmology Annual Meeting, Marshfield. Info: Michael R McCormick, MD, Secretary-Treasurer, 102 East Main St, Waukesha, Wis 53186 (phone: 414/547-3352).

SEPTEMBER 22-25, 1982: *7th Annual Nuclear Cardiology Symposium,* Red Carpet Hotel, Milwaukee. Sponsored by Mount Sinai Medical Center, Milwaukee; University of Wisconsin-Extension Continuing Medical Education, University of Wisconsin School of Medicine, Milwaukee Clinical Campus, Cardiovascular Disease Program; American Health Association; and Society of Nuclear Medicine. AMA Category 1, VOICE, University of Wisconsin-Extension Continuing Education Hours. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, WI 53706; ph 608/263-2856.

SEPTEMBER 23, 1982: Wisconsin State Medical Golf Association Annual Meeting and Golf Outing, Kenosha. For details contact Ron Oschman, Executive Secretary, phone 414/226-6151. g7-8/82

SEPTEMBER 24-25, 1982: *American Heart Association's Advanced Cardiac Life Support Course (ACLS),* Marshfield Clinic. Sponsored by the Marshfield Clinic. Info: Office of Medical Education, 1000 North Oak Ave, Marshfield, Wis 54449; ph 715/387-5207.

September 24-25, 1982: *Update in Medicine and Technology for the General Dentist,* Madison. Sponsored by University of Wisconsin, Continuing Medical Education; University of Wisconsin School of Medicine; and Wisconsin Chapter, Academy of General Dentistry. Credit, University of Wisconsin Continuing Education hours; Fellowship and Mastership credits, Academy of General Dentistry. Football tickets available for Wisconsin vs Toledo game, Homecoming weekend. Info: Sarah Z Aslakson, Continuing Medical Education, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

SEPTEMBER 24-25, 1982: *Seminars in Pediatrics,* Madison. Sponsored by the University of Wisconsin Department of Pediatrics and University of Wisconsin-Extension Department of Continuing Medical Education. Fee: $140/physicians; $85/nurses, residents, others. AMA Category I, AOA and AAFP applied for, University of Wisconsin CEU's all 12 hours. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

SEPTEMBER 30-OCTOBER 1, 1982: *The First Annual Interdisciplinary Conference on Geriatrics and Oral Health,* Marriott Inn, Brookfield. Sponsored by Section of Geriatrics and Gerontology, Department of Medicine, The Medical College of Wisconsin, and Wood Veterans Administration Medical Center, Milwaukee. Details in box elsewhere in this section.

OCTOBER 1-2, 1982: *Wisconsin Association of Blood Banks* Fall Seminar, Oshkosh. Contact: Jay Menitive, MD, Blood Center of SE Wisconsin, 1701 West Wisconsin Ave, Milwaukee, Wis 53233 (608) 255-0021.

OCTOBER 9, 1982: Second Annual Meeting of the *Wisconsin Association of Senior Physicians,* at State Medical Society Headquarters in Madison. Info: Norman Clausen, MD, President, WASP, PO Box 1109, Madison, Wis 53701.

OCTOBER 14-15, 1982: *Aging and Illness in Primary Care: The Second Symposium on Basic and Clinical Science Foundations,* Madison. Sponsored by University of Wisconsin-Extension, Continuing Medical Education; University of Wisconsin

Medical School Departments of Medicine and Family Medicine and Practice and Wisconsin Regional Geriatric Center, Milwaukee. AMA Category 1, AOA Category 2-D, AAFP, University of Wisconsin CEU's—all 14 hours. Fee: $200/physicians, $125/nurse, residents, others. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

OCTOBER 16, 1982: Wisconsin Radiological Society, Concourse Hotel, Madison.

OCTOBER 19, 1982: *Suicide Assessment and Intervention,* Stevens Point. Sponsored by University of Wisconsin-Extension, Dept of Allied Health and University of Wisconsin-Extension, Dept of Mental Health. AMA Category 1, 6 hours; University of Wisconsin-Extension Continuing Education Hours, 6 hours. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

OCTOBER 20, 1982: *Suicide Assessment and Intervention,* Beaver Dam. Sponsored by University of Wisconsin-Extension, Dept of Allied Health and University of Wisconsin-Extension, Dept of Mental Health. AMA Category 1, 6 hours; University of Wisconsin-Extension Continuing Education Hours, 6 hours. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

OCTOBER 20, 1982: Milwaukee Ophthalmological Society Fall Meeting at University Club in Milwaukee. Info: Michael R McCormick, MD, Secretary, 102 East Main St, Waukesha, Wis 53186 (phone: 414/547-3352).

OCTOBER 21-23, 1982: *Sick, Criminal, or Nuisance? How to Deal with the Mentally Ill Lawbreaker in the Community,* Inn on the Park, Madison. Sponsored by the University of Wisconsin-Extension Continuing Medical Education; University of Wisconsin School of Medicine, Dept of Psychiatry in cooperation with Continuing Legal Education; University of Wisconsin-Extension and the State of Wisconsin Justice Department. Info: Ann Bailey, Admin, CME, 454 WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2854.

NOVEMBER 4-6, 1982: *4th Annual Respiratory Critical Care Symposium: Update on Current Concepts,* Inn on the Park Hotel, Madison. Sponsored by the University of Wisconsin-Extension Dept of Continuing Medical Education; University of Wisconsin Dept of Nursing; Pulmonary Section of School of Medicine; and Respiratory Therapy Dept and Center for Trauma and Life Support. Credit: AMA, University of Wisconsin Continuing Education hours, AOA, AAFP, College of Emergency Physicians—all 18 hours. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

NOVEMBER 5, 1982: Wisconsin Orthopaedic Society, Olympia Resort, Oconomowoc.

NOVEMBER 5-6, 1982: *Wisconsin Neurosurgical Society,* Marriott Inn, Brookfield.

NOVEMBER 6-7, 1982: Wisconsin Allergy Society, Pioneer Inn, Oshkosh.

NOVEMBER 8, 1982: *Suicide Assessment and Intervention,* Milwaukee. Sponsored by University of Wisconsin-Extension, Dept of Allied Health and University of Wisconsin-Extension, Dept of Mental Health. AMA Category 1, 6 hours; University of Wisconsin-Extension Continuing Education Hours, 6 hours. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

NOVEMBER 9, 1982: *Suicide Assessment and Intervention,* Kenosha. Sponsored by University of Wisconsin-Extension, Dept of Allied Health and University of Wisconsin-Extension, Dept of Mental Health. AMA Category 1, 6 hours; University of Wisconsin-Extension Continuing Education Hours, 6 hours. Info Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

THE FIRST ANNUAL INTERDISCIPLINARY CONFERENCE ON GERIATRICS AND ORAL HEALTH

September 30 and October 1, 1982

Marriott Inn, Brookfield

Sponsored by Section of Geriatrics and Gerontology, Department of Medicine, The Medical College of Wisconsin and Wood Veterans Administration Medical Center, Milwaukee

Thursday, Sept 30; 8:00am-4:00-pm

- Aging—An Overview, *Steven R Gambert, MD, FACP*
- Age-Related Sensory Changes, *Edmund H Duthie, MD*
- Reminiscence as a Tool for Interacting with the Elderly, *Beverly A Priefer, RN*
- Drug Usage in the Elderly, *Steven R Gambert, MD, FACP*
- Metabolic Bone Disorders, *Panayiotis D Tsitouras, MD*
- Growing Young versus Growing Old, *Emanuel L Lifschutz, PhD*

Friday, Oct 1; 8:15am-4:30pm

- Overview of Geriatric Oral Health, *Patrick M Lloyd, DDS*
- Oral Health and its Effect on Diet and Aging, *J Crystal Baxter, DDS*
- Oral Health and Cerebrovascular Disability, *Charles O Kolthoff, DDS, MS*
- Oral Manifestations of Aging, *Patrick M Lloyd, DDS*
- Management of the Atrophic Alveolar Ridge, *Kenneth P Sobczak, DDS*
- Pre-prosthodontic Surgery for the Geriatric Patient, *Michael D Head, DMD*

Accreditation: 13 credit hours approved by American Central Association Continuing Education Registry, MCW accredited by the ACCME approved 13 Category I credits, MCW accredited by the Council of the Continuing Education Unit, meets criteria for 1.3 CEU.

Fee: $150/dentists and physicians; $75/nurses and allied health professionals; $50/students, includes two luncheons.

Info: Steven R Gambert, MD, FACP, Section of Geriatrics and Gerontology (111P), Wood Veterans Administration Medical Center, 5000 West National Ave, Milwaukee, Wis 53193.

NOVEMBER 13-14, 1982: *Therapeutics 1982,* Madison. Sponsored by University of Wisconsin-Extension, Dept of Continuing Medical Education; and University of Wisconsin School of Medicine, Dept of Medicine. Credit: University of Wisconsin-Extension CEU's, AMA Category I, AAFP and AOA approved for—all 9 hours. Info: Sarah Z Aslakson, Continuing Medical Education, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

DECEMBER 4, 1982: *Wisconsin Chapter, American College of Surgeons,* Hyatt Regency, Milwaukee.

JANUARY 12-14, 1983: *Clinical Cancer Conference,* The Telemark Lodge, Cable. Sponsored by Marshfield Clinic, Duluth Clinic, Wisconsin Cancer Society and the Minnesota Cancer Society. Info: Office of Medical Education, 1000 North Oak Ave, Marshfield, Wis 54449; ph 715/387-5207.

FEBRUARY 16-18, 1983: *Medical/Surgical Update '83.* The Telemark Lodge, Cable. Sponsored by Marshfield Clinic. Info: Office of Medical Education, 1000 North Oak Ave, Marshfield, Wis 54449; ph 715/387-5207.

OTHERS

SEPTEMBER 11, 1982 (California): *The Whole and Not the Part: Treating the Low-Back Patient,* Pacifica Hotel, 6161 Cen-

WISCONSIN SPECIALTY SOCIETY MEETINGS: 1982-1983

Wisconsin Otolaryngological Society, Aug 28-29, 1982, The Abbey, Lake Geneva

Wisconsin Neurological Society, Fall Meeting, Sept 17-19, American Club, Kohler

Wisconsin Surgical Society, Sept 9-10, 1982, Lutheran Hospital, La Crosse

Wisconsin Society of Internal Medicine, Sept 9-11, 1982, Holiday Inn (Downtown), Green Bay

Wisconsin Society of Anesthesiologists, Sept 9-12, 1982, Concourse Hotel, Madison

Wisconsin Society of Pathologists, Sept 18, 1982, Medical College of Wisconsin, Milwaukee

Wisconsin-Upper Michigan Society of Ophthalmology Annual Meeting, Sept 18, 1982, Marshfield

Wisconsin Radiological Society, Oct 16, 1982, Concourse Hotel, Madison

Wisconsin Orthopaedic Society, Nov 5, 1982, Olympia Resort, Oconomowoc

Wisconsin Allergy Society, Nov 6-7, 1982, Pioneer Inn, Oshkosh

Wisconsin Neurosurgical Society, Nov 5-6, 1982, Marriott Inn, Brookfield

Wisconsin Chapter: American College of Emergency Physicians, Oct 14-15, 1982, Midway Motor Lodge, Brookfield

Wisconsin Orthopaedic Society, Nov 5, 1982, Olympia Resort, Oconomowoc

Wisconsin Chapter: American College of Surgeons, Dec 4, 1982, Hyatt-Regency, Milwaukee

* * *

SPECIALTY SOCIETY MEETINGS TO BE HELD IN CONJUNCTION WITH SMS ANNUAL MEETING, March 24-26, 1983, Milwaukee

Wisconsin Allergy Society
Wisconsin Orthopaedic Society
Wisconsin Psychiatric Association
Wisconsin Society of Internal Medicine
Wisconsin Society of Pathologists
Wisconsin Society of Physical Medicine and Rehabilitation
Wisconsin Society of Plastic Surgeons
Wisconsin Society for Preventive Medicine
Wisconsin Society of Radiation Oncologists
Wisconsin Surgical Society

FIFTH NATIONAL CONFERENCE ON THE Impaired Physician

Sponsored by the AMA, Oregon Medical Assocation and Multnomah County Medical Society

September 22-25—Portland, Oregon

Highlights—

- George D Lundberg, MD, editor of the *Journal of the American Medical Association,* will talk about "Physician Health in a Changing Society."
- Martin R Lipp, MD, San Francisco psychiatrist and author, will present "Evolution of the Physician."
- S Spence Meighan, MD, Portland psychiatrist, will present "Changing Face of Medicine: New Contexts for Impairment in the Future."
- Rogers J Smith, MD, forensic psychiatrist practicing in Portland and a member of the AMA Council on Scientific Affairs, will be a luncheon speaker.
- Thomas E Bittker, MD, psychiatrist and chairman of the Arizona Medical Association Physician's Health Committee, will moderate a panel discussion on "The Physician's Family: Is It Different?"
- Ralph Crawshaw, MD, Portland psychiatrist and chairman of the AMA conference, will moderate a panel on "The Educational System: How Does It Impact on Impairment?"
- Douglas A Sargent, MD, JD, Grosse Point Farms, Michigan, psychiatrists, will present a progress report on the Joint AMA/American Psychiatric Association Physician Mortality Project. Doctor Sargent is chairman of the AMA Panel on Physician Mortality.
- Concurrent discussion groups, revolving around family, legal, educational, and treatment issues—led by physicians and other professionals knowledgeable in the fields of chemical and mental impairment.
- Focus groups will meet for free-form discussion on: the concerns of state licensing boards, various state and county medical society programs for impaired physicians, International Doctors in Alcoholics Anonymous, families of impaired physicians, and impairment among other professions.

Further details—
Jane Coughlin of the AMA (phone 312/751-5109); or write: AMA, Media Relations Department, 535 North Dearborn St, Chicago, Illinois 60610.

tinela Avenue, Culver City, California. Sponsored by Riverside Hospital of North Hollywood, California, an American Medical International, Inc (AMI) affiliate. Continuing education credit available. Info: "The Whole and Not the Part" Seminar, 2217 Nicollet Avenue South, Minneapolis, Minn 55404, or call 800/328-5216 toll free. p8/82

SEPTEMBER 16-17, 1982 (Minnesota): *Current Clinical Cardiology Seminar,* 2nd Annual Jesse E Edwards, MD, Lectureship highlights, at United Hospitals, St Paul, MN. See details in box elsewhere in this section.

SEPTEMBER 22-25, 1982 (Oregon): *AMA Fifth National Conference on The Impaired Physician,* Portland, Oregon. Co-sponsored by the Oregon Medical Association and Multnomah County Medical Society. Info: AMA Fifth National Conference on the Impaired Physician, AMA Dept of Meeting Services, 535 N Dearborn St, Chicago, IL 60610; ph 312/751-6503. g8/82

SEPTEMBER 23-24, 1982 (New York): *The Fifth Annual Current Concerns in Adolescent Medicine,* Warwick Hotel, 65 West 54th St, New York, New York. Sponsored by The Division of Adolescent Medicine of the Department of Pediatrics, Long Island Jewish-Hillside Medical Center, New York. Approved 14 credit hours in Category 1 from ACCME. Info: Ann J Boehme, Continuing Education Coordinator, Long Island Jewish-Hillside Medical Center, New Hyde Park, NY 11042; ph 212/470-2114. 8/82

OCTOBER 23-28, 1982 (New York): American Academy of Pediatrics (AAP) 1982 Annual Meeting, Hilton Hotel, New York. Info: Allison Waitley, Registration Supervisor, AAP, PO Box 1034, Evanston, IL 60204.

OCTOBER 23-30, 1982 (Florida): *A Basic and Advanced Course in Colposcopy and Management of Patients with Cervical Intraepithelial Neoplasia,* offered by the Medical College of Wisconsin, Milwaukee, with course to be held in the Omni Hotel, Miami, Florida and on board the cruise ship M/S Southward. The MCW, accredited by ACCME, certifies that this program meets the criteria for 37 Category 1 credits. Info: Adolf Stafl, MD, Associate Professor of Gynecology & Obstetrics, MCW, 8700 West Wisconsin Ave, Milwaukee, Wis 53226.

NOVEMBER 1-4, 1982: (California): 67th Annual Scientific Assembly of Interstate Postgraduate Medical Association at Town and Country Hotel, San Diego. Approved 24 hours of Category 1 and 4 hours of Category 5 credit of AMA-PRA. Info: Interstate Postgraduate Medical Association, PO Box 1109, Madison, Wis 53701.

DECEMBER 8-10, 1982 (Illinois): *Neurology for the Non-Neurologist,* The Westin Hotel, Chicago. Sponsored by Rush-Presbyterian-St Luke's Medical Center. Approved 20 credit hours of Category 1 AMA-PRA. Info: University of Office of Continuing Education, Rush-Presbyterian-St Luke's Medical Center, 600 South Paulina, Chicago, IL 60612; ph 312/942-7095. 8-11/82

FEBRUARY 23-MARCH 1, 1983 (Hawaii): *Adolescent/Young Adult Medicine,* Wailea Beach Hotel, Maui, Hawaii. 20 hours. Sponsored by Hurley Medical Center, Dept of Continuing Education, 1 Hurley Plaza, Flint, Mich 48502; ph 313/766-0142. 8-9/82

AMA

DECEMBER 5-8, 1982: Interim AMA House of Delegates, Miami Beach, Fl.

JUNE 19-23, 1983: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 4-7, 1983: Interim AMA House of Delegates, Los Angeles, CA.

JUNE 17-21, 1984: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 5-7, 1984: Interim AMA House of Delegates, Honolulu, Hawaii. ■

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SECOND ANNUAL JESSE E EDWARDS, MD LECTURESHIP—SEMINAR HIGHLIGHTS

Current Clinical Cardiology

September 16-17, 1982—St Paul, Minn

Seminar is tailored to clinical interests of Family Physicians and Internists. It will provide a practical review and update of current diagnostic and therapeutic advances in the management of cardiovascular disease. Sponsored by United Hospitals of St Paul.

The Jesse Edwards Lecture this year will be presented by Prof dr C A Wangenvoort of the University of Amsterdam, The Netherlands. His talk is titled "The Point of No Return in Hypertensive Pulmonary Vascular Disease."

Registration fee: $75 includes luncheons, reception and course syllabus. For accreditation and registration information, contact the:

Medical Staff Office, United Hospitals
333 N Smith Ave, St Paul, MN 55102
Phone: 612/298-8558 p8/82

News You Can Use

By EARL THAYER, Secretary/BERNIE MARONEY, Assistant Secretary

ANTITRUST IN HEALTH INDUSTRY FOCUS OF COURT DECISIONS. The Supreme Court recently handed down three decisions which may significantly increase the exposure of physicians, some health organizations, and indeed, the entire health industry, to antitrust liability.

In *Arizona v Maricopa County Medical Society,* the Supreme Court held in a 4-3 decision that maximum fee schedules adopted by physician-controlled foundations for medical care (FMCs) violated Section 1 of the Sherman Antitrust Act. The court declined to provide much specific guidance concerning other activities that would constitute price-fixing by competing physicians. While certain questions raised by Maricopa County could pose legal problems for physician-controlled HMOs, the majority opinion did distinguish arrangements, characteristic of HMOs and joint ventures, where physicians themselves underwrite a portion of the businesses' risk. The court hinted that HMOs and their affiliated IPAs would not be viewed under the rule.

Blue Shield of Virginia v McCready, the second case decided by the Supreme Court, arose out of Blue Shield's illegal boycott of clinical psychologists, under which subscribers could not be reimbursed for treatment by a clinical psychologist unless supervised by a physician. McCready held, by a 5 to 4 margin, that subscribers may bring a treble-damages antitrust claim against a health plan where the damages are direct and demonstrable in order to seek to recover out-of-pocket expenses incurred as a result of a health plan's boycott of nonphysician providers.

In the third case, *Union Labor Life Ins Co v Pireno,* the Court held (6-3) that private peer review is not exempt from the antitrust laws. Nevertheless, nothing in any of the three cases affects the validity of voluntary peer review activity, as long as that activity does not involve binding decisions by a physician-controlled organization regarding either fee schedules or the price of individual services. Practices involving utilization review for Medicare or Medicaid would be immune from antitrust laws. Practices involving private review is not immune, but the Federal Trade Commission (FTC) has made it clear that utilization and fee review are not violations of the antitrust laws so long as the physcian-controlled organization merely recommends, but does not make the final decision regarding the appropriateness of care or the fee in question.

In a related matter, a coalition of 33 professional, consumer and labor union groups July 19 announced their opposition to a bill by Sen Robert W Kasten Jr, (R-Wis) to exempt licensed professionals from FTC regulation. The bill is supported by the American Medical, Dental, Bar and Optometric Associations. The proposal, which was recommended for passage from the Senate Commerce Committee last May, has not yet been scheduled for a vote in the Senate.

STATE TO DEVELOP HMO-TYPE INSURANCE PROGRAM FOR EMPLOYEES. In an effort to curtail increasing health insurance costs, the State's Group Insurance Board has decided to develop a new insurance program for 58,000 state employees and their families that will limit employee choices of physicians and clinics. Under the program, state employees would have limited healthcare choices through a health maintenance organization concept. In addition, employees and families would be able to use only those physicians and clinics with whom the state has contracts.

A similar program is underway in California, where bills have been passed in the state's legislature to try to hold the line on spiraling healthcare costs. One bill would allow a state commission to negotiate flat-rate contracts with hospitals to provide inpatient care for the state's three million Medi-Cal recipients. The second bill would permit private insurance companies to negotiate similar contracts for group healthcare plans, not only with hospitals but also with physicians. Any savings in the claims would be passed along in the form of lower premiums. Both the California Hospital Association and the California Medical Association are opposed to the reform.

1982-83 PHYSICIAN DIRECTORIES PUBLISHED. The State Medical Examining Board has announced that the 1982-83 directory of physicians currently registered in Wisconsin is now available. Cost is $5.00 per copy plus 5% Wisconsin sales tax. Prepaid orders should be mailed to: Medical Examining Board, PO Box 8935, Madison, WI 53708. ■

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a continuing record of high clinical effectiveness against common uropathogens

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effective against both major otic pathogens... with *b.i.d.* convenience

in acute exacerbations of chronic bronchitis in adults...
clears the sputum and lowers its volume...on *b.i.d.* dosage

in shigellosis...
faster relief of diarrhea than with ampicillin[2]

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Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. *Note.* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.
For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.
For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.
For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.
Also for the treatment of documented *Pneumocystis carinii* pneumonitis.
Contraindications: Hypersensitivity to trimethoprim or sulfonamides, patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.
Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.
Precautions: *General.* Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.
Pregnancy. Teratogenic Effects. Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.
Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias.* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions.* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions.* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea, pseudomembranous colitis and pancreatitis. *CNS reactions.* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions.* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.
Dosage: Not recommended for infants less than two months of age.
URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN
Adults. Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.
Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.
For patients with renal impairment. Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.
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Usual adult dosage. 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days.
PNEUMOCYSTIS CARINII PNEUMONITIS:
Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.
Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100, Tel-E-Dose® packages of 100, Prescription Paks of 20 and 28. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500, Tel-E-Dose® packages of 100, Prescription Paks of 40. *Pediatric Suspension,* containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); cherry flavored—bottles of 100 ml and 16 oz (1 pint). *Suspension,* containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).

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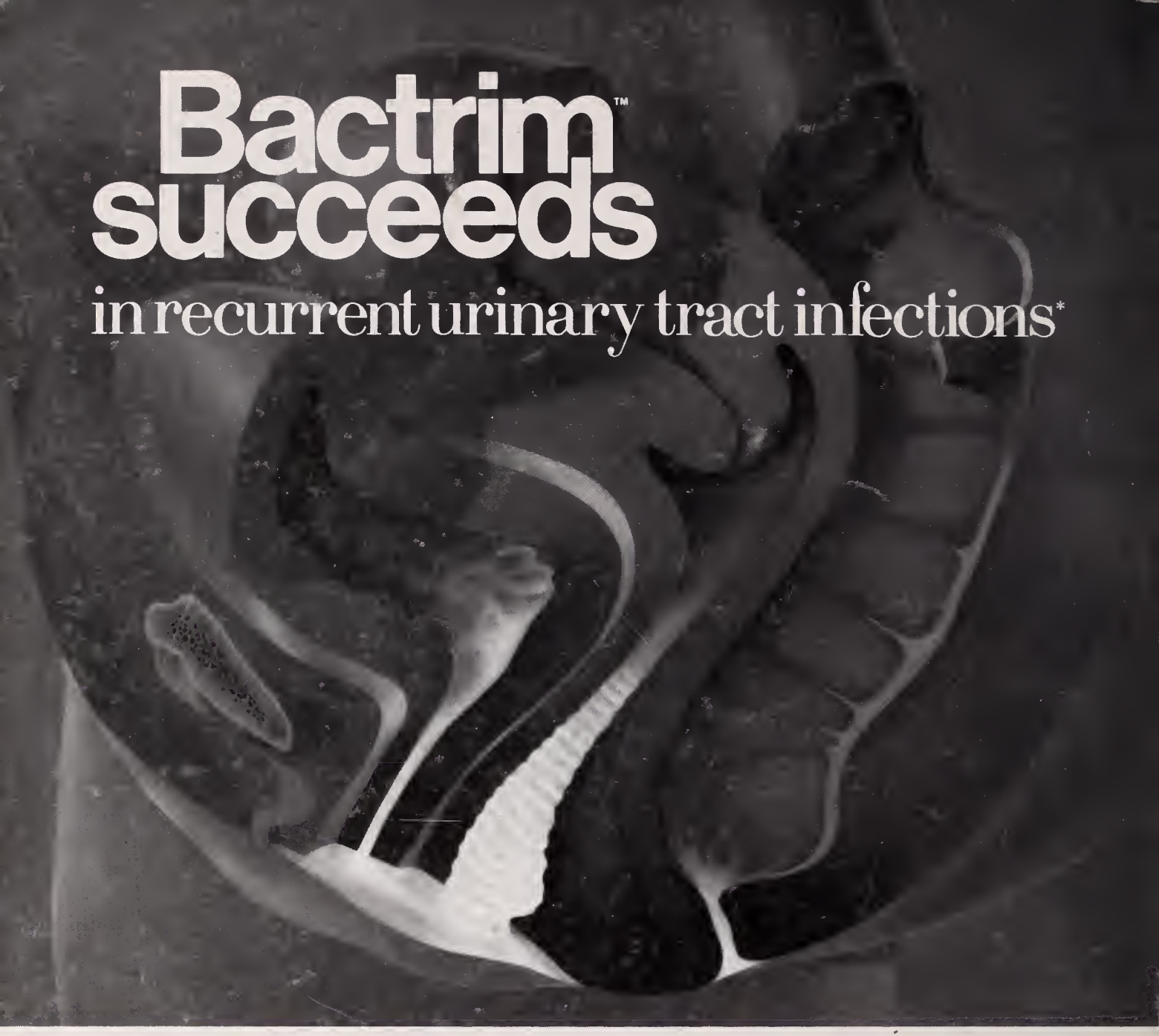

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1. Rubin RH, Swartz MN: *N Engl J Med 303* 426-432, Aug 21, 1980. **2.** Data on file, Medical Department, Hoffmann-La Roche Inc.

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WISCONSIN MEDICAL JOURNAL

SEPTEMBER 1982

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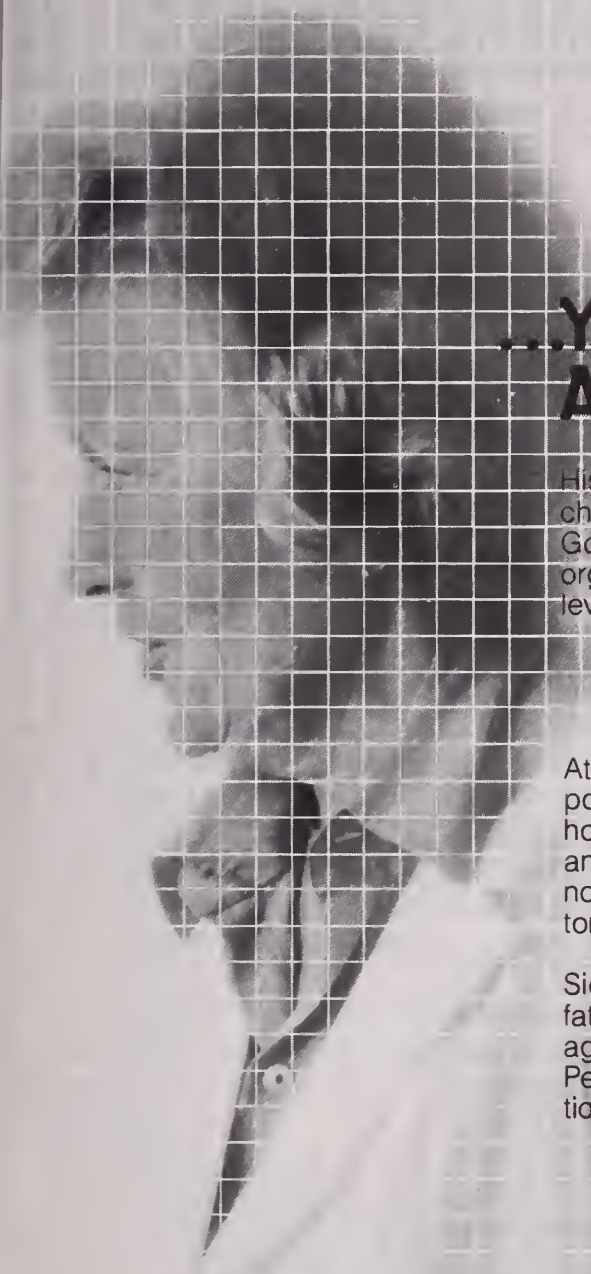

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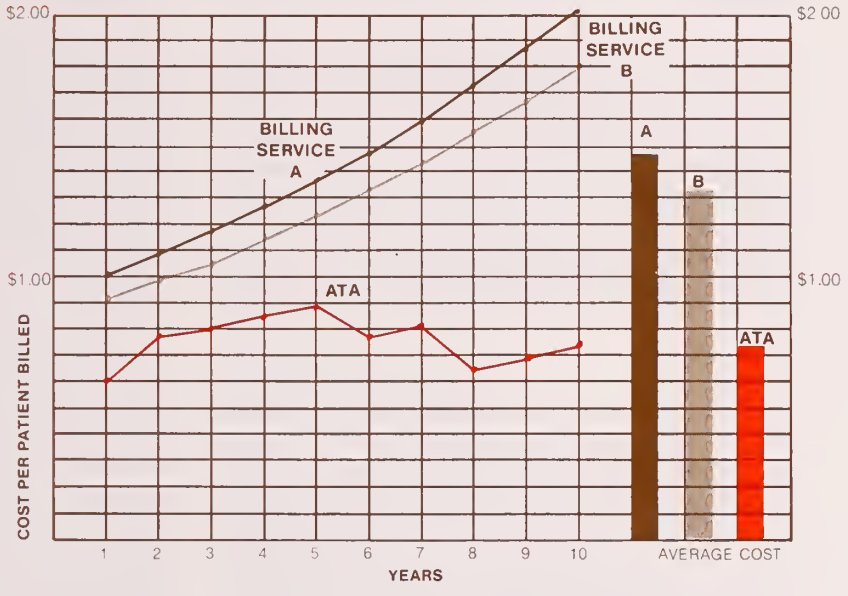

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President's Page

.....Gerald C Kempthorne, MD

A time for restraint on fee increases

THE LAY PRESS IS currently devoting considerable coverage to the continuing problem of increasing health care costs. It is pointing the finger of "blame" at hospitals and doctors. Our government tells us that nearly 10% of our Gross National Product goes for "health care." Doctor bills went up 16.9% in 1981 according to the Health Care Financing Administration. However, we all know that hospital costs have been increasing faster than any other segment of the health care delivery system.

The *Chicago Tribune,* on August 15, 1982 published a major article about comparable incomes around the world. It stated: "Doctors, like lawyers, are amazingly secretive about how much they earn, and the general suspicion is that they make staggering and often undisclosed sums of money for treating people's illnesses. Frequently, such suspicions are well-founded." The article goes further to state: "The best-paid physicians are immensely overpaid in relation to the income standards for other professions wherever they live, be it Paris, Calcutta, La Paz or Chicago. In the United States the average income for all physicians is from $69,000 to $75,000 a year."

The newspaper elaborated on the "average income of some specialists" to be in the range of $400,000 to $500,000 a year. It was suggested in the article that a significant number of doctors earn $1 million or more.

In a special report published by the Bureau of National Affairs in Washington, DC, it has been reported that 36 companies have imposed salary freezes—affecting 250,000 white-collar workers during the first six months of 1982. Thirty-three other companies cut the salaries of more than 50,000 white-collar workers. Other companies have cut back on various benefits. Many companies have delayed salary reviews, and other companies have laid off white-collar workers rather than impose other cutbacks.

The American Podiatry Association recently recommended a "fee freeze" to their national membership in order to show their good faith in the effort to control escalating health care costs in their field. It will be interesting to see if the Federal Trade Commission is "interested" in pursuing any organization when it acts collectively to *restrain* fee increases—as a group.

The national economy is clearly in a recession. Unemployment is a serious problem. Fortunately, inflation is partially under control. Confidence is waning in support of governments. People still seem to clamor for the best possible health care—regardless of the costs. Efforts at controlling the escalation of health care expenditures continue to dominate the minds of all concerned about the problem—from governments to the interested consumer. However, efforts at control are lost in the "mind boggling complexities" of the enigma.

Physicians have been described as "gatekeepers" by certain elements of our society. I propose that might not be an inappropriate title if we hope to retain the medical model of health care. There are those folks who would love to see our superior role in the health care system greatly diminished. When the medical model loses its obvious influential role, quality of care will be lowered. Therefore, it is incumbent for physicians to be effective and concerned "gatekeepers" if that title is to be around our mantle. I seriously doubt if we will ever be able to "shake" that image. Therefore, let us make the most of the heritage of providing the physician input to the system of health care. Naturally that means a pervasive and ongoing surveillance of what goes on in the system. We can no longer be a healer to our patients exclusively. We must take up the struggle to control costs.

Recently, I took the opportunity to discuss fees with my colleagues in the leadership. It is quite obvious to me that it is timely for the medical profession to exercise the greatest effort at attempting to "stem the tide" of ever-increasing health care costs. If this means making every conscious effort at holding down fee increases, then now is the time to do it. I would predict that not many physicians are suffering financially, and a restraint on fee increases during the current state of national turmoil would be received very favorably by our patients.

Everybody talks about the cost of health care. Who is really doing anything about it? Did you ever see a patient in a hospital talk to the hospital administrator about the cost of his care? Can you imagine the brick walls of a hospital responding to the concern of a frustrated patient with an inflated hospital bill. Physicians are human and by nature concerned about the total welfare of their patients. We *can* and *should* respond to the costs our patients must absorb for their health care. If the brick walls are unresponsive, we should not be! ■

Editorials

WAYNE J BOULANGER, MD, *Editorial Director*

Official positions of the Society will be expressly identified as such; all others are views of the writer and not necessarily those of the Society.

Freedom

RECENTLY A NINE-year-old Wisconsin girl died from diphtheria. This was the first reported Wisconsin death from diphtheria since 1971. The girl had not been immunized and apparently had contracted the disease at a Christian Science camp in Colorado. After her stay at camp she rode home on a bus crowded with children.

Also, there was a recent network television program that discussed the risks associated with pertussis vaccine. Unfortunately, the program was unbalanced in that it went on at great length about the frequency to reactions from pertussis vaccine but very little about the serious complications arising from the disease. This, of course, will give the anti-vaccination, anti-immunization crowd some more ammunition.

The Wisconsin Division of Health points out that in the 1940s before pertussis vaccine was available there were as many as 250,000 cases and 7,000 deaths annually due to pertussis in the United States. However, during the past ten years, only 1,000 to 3,000 cases and 5 to 20 deaths were reported annually. Thus, there would be a seventy-fold increase in cases and nearly a four-fold increase in deaths without an immunization program against pertussis.

Several years ago there was a minor outbreak of polio that occurred in a camp run by a religious group that was opposed to the use of all vaccines.

Freedom of religion is guaranteed by the Constitution. However, freedom from diphtheria, pertussis, and polio should also be the right of every child.—VSF

H Kent Tenney, MD

THE STATE MEDICAL SOCIETY, the University of Wisconsin Medical School, and the medical community lost a good friend when Dr H Kent Tenney died on August 15. During his 90 years, his accomplishments covered many fields.

He descended from a pioneer Wisconsin medical family and was proud to claim an Ottawa Indian Chief as an ancestor.

He was an emeritus professor of pediatrics at the University of Wisconsin Medical School and had been awarded the Medical School's Emeritus Faculty Citation.

In 1976 we published an editorial commending Doctor Tenney for his long service with the statewide radio programs. Between 1961 and 1976 he had taped 832 March of Medicine programs all under the sponsorship of the State Medical Society working with Radio Station WHA. These were broadcast over 30 radio stations and were extremely popular.

In April 1982 Doctor Tenney's last article was published in the *Wisconsin Medical Journal.* This was entitled "Old Pediatrics," and Doctor Tenney had some suggestions for his younger colleagues.

Doctor Tenney had been both president of the Dane County Medical Society and the State Medical Society of Wisconsin as well as State Chairman of the American Academy of Pediatrics. His active role in organized medicine should be an example to other physicians in the state. His standard sign-off at the conclusion of his radio program was good advice to all of us: "So long, folks. Now take care of yourself and have fun!" Doctor Tenney enjoyed a full life and had fun—whether practicing pediatrics, teaching medical students, counseling anxious mothers, or still skiing well into his eighties. —VSF

Confidentiality

AT ITS JULY 17 meeting, the Board of Directors was informed of attempts by a litigant to subpoena records of the State Medical Society's impaired physician program. These records would be used in a civil suit brought by a patient against a physician.

The Board decided to fight the subpoena.

That decision will cost the Society an estimated $6,000 to $10,000.

It is money well spent, but it is an expenditure which never should have been necessary.

If records of medical society committee deliberations having to do with matters such as this can be held open to the public, then peer review will soon cease to exist; and the public will be the loser.

This is one battle which must be fought no matter what the cost.—WJB

Due process—not a one way street

THE STATE MEDICAL Examining Board has taken criticism from the press this year because of its failure to penalize some physicians who have been found by the Patient Compensation Panel to be guilty of negligence. The same editorial and feature writers who will defend to their last drop of ink the rights of mass murderers, rapists, and terrorists find it incomprehensible that a doctor should be allowed to continue to practice after he has accidentally injured a patient through negligence.

Negligence and unprofessional conduct are not interchangeable terms, although in the eyes of the newspapers, they seem to be.

The definition of unprofessional conduct as recorded in the Wisconsin Administrative Code appears in this year's *Blue Book* on page 43. It occupies the entire

page. On the other hand, negligence is not defined in the code at all. Perhaps it ought to be, if it is going to be used by the State Medical Examining Board in its official opinions.

What the newspaper writers apparently choose to ignore is the simple fact that doctors as United States citizens have rights, too. One of these rights accords them due process when accused, and the other assumes innocence until proof of guilt, no matter how cut-and-dried the case may seem.

The State Medical Examining Board in its role as judge and jury cannot act precipitously without doing the doctor harm. If prompt steps must be taken to protect the public, they must logically come from the Board of Directors of the hospital staff which controls the privileges of the physician. If there is due cause, these privileges may be suspended until the issue is resolved.

There will be instances where acts detrimental to the health of the patient take place outside the hospital setting. It is these situations which cause the greatest difficulty and which up to now haven't been satisfactorily resolved. None of the normal peer review mechanisms addresses the problem, and often recognition of malpractice occurs late. In such circumstances, complaints will reach the State Medical Examining Board eventually from various sources. It is the duty of the Board to investigate promptly, but investigations take time if they are to be complete and fair to all.

If the Board has indeed been lax, it is in the matter of length of time it requires to complete investigations. That may be a manpower problem as much as anything, and that can be remedied. What the Board cannot do is allow outside pressures to interfere with due process.—WJB

Good question

AT LEAST ONE HOSPITAL in Wisconsin requires each applicant for the medical staff to swear under threat of denial or dismissal that he or she will "shun unwarranted publicity, dishonest money-seeking and commercialism, to refuse money trades with consultants, practitioners, makers of surgical appliances and optical instruments, or others; to make my fees commensurate with the service rendered and with the patients' rights; and to avoid discrediting my associates by taking unwarranted compensation."

One wonders why the agreement doesn't bind the hospital to the same conditions.—ERT■

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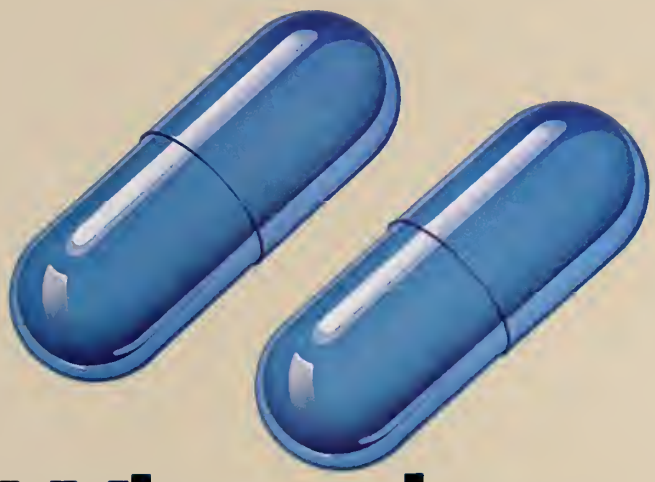

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Note: Culture and susceptibility tests should be initiated prior to and during therapy.

CONTRAINDICATIONS: In patients with known hypersensitivity to the cephalosporin group of antibiotics.

WARNINGS; *Use cephalosporin derivatives with great caution in penicillin-sensitive patients since there is clinical and laboratory evidence of partial cross-allergenicity of the two groups of antibiotics; there are instances of reactions to both drug classes (including anaphylaxis after parenteral use).* In persons who have demonstrated some form of allergy, particularly to drugs, use antibiotics, including cephradine, cautiously and only when absolutely necessary.

Pseudomembranous colitis has been reported with the use of cephalosporins (and other broad spectrum antibiotics); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with antibiotic use. Treatment with broad spectrum antibiotics alters normal flora of the colon and may permit overgrowth of clostridia. Studies indicate a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis. Cholestyramine and colestipol resins have been shown to bind the toxin *in vitro.* Mild cases of colitis may respond to drug discontinuance alone. Manage moderate to severe cases with fluid, electrolyte and protein supplementation as indicated. Oral vancomycin is the treatment of choice for antibiotic-associated pseudomembranous colitis

produced by *C. difficile* when the colitis is severe or is not relieved by drug discontinuance; consider other causes of colitis.

PRECAUTIONS: General: Follow patients carefully to detect any side effects or unusual manifestations of drug idiosyncrasy. If a hypersensitivity reaction occurs, discontinue the drug and treat the patient with the usual agents, e.g., pressor amines, antihistamines, or corticosteroids. Administer cephradine with caution in the presence of markedly impaired renal function. In patients with known or suspected renal impairment, make careful clinical observation and appropriate laboratory studies prior to and during therapy as cephradine accumulates in the serum and tissues. See package insert for information on treatment of patients with impaired renal function. Prescribe cephradine with caution in individuals with a history of gastrointestinal disease, particularly colitis. Prolonged use of antibiotics may promote the overgrowth of nonsusceptible organisms. Take appropriate measures should superinfection occur during therapy. Indicated surgical procedures should be performed in conjunction with antibiotic therapy.

Information for Patients: Caution diabetic patients that false results may occur with urine glucose tests (see PRECAUTIONS, Drug/Laboratory Test Interactions). Advise the patient to comply with the full course of therapy even if he begins to feel better and to take a missed dose as soon as possible. Tell the patient he may take this medication with food or milk since G.I. upset may be a factor in compliance with the dosage regimen. The patient should report current use of any medicines and should be cautioned not to take other medications unless the physician knows and approves of their use (see PRECAUTIONS, Drug Interactions).

Laboratory Tests: In patients with known or suspected renal impairment, it is advisable to monitor renal function.

Drug Interactions: When administered concurrently, the following drugs may interact with cephalosporins:

Other antibacterial agents — Bacteriostats may interfere with the bactericidal action of cephalosporins in acute infection; other agents, e.g., aminoglycosides, colistin, polymyxins, vancomycin, may increase the possibility of nephrotoxicity.

Diuretics (potent "loop diuretics," e.g., furosemide and ethacrynic acid) — Enhanced possibility for renal toxicity.

Probenecid — Increased and prolonged blood levels of cephalosporins, resulting in increased risk of nephrotoxicity.

Drug/Laboratory Test Interactions: After treatment with cephradine, a false-positive reaction for glucose in the urine may occur with Benedict's solution, Fehling's solution, or with Clinitest® tablets, but not with enzyme-based tests such as Clinistix® and Tes-Tape®. False-positive Coombs test results may occur in newborns whose mothers received a cephalosporin prior to delivery. Cephalosporins have been reported to cause false-positive reactions in tests for urinary proteins which use sulfosalicylic acid, false elevations of urinary 17-ketosteroid values, and prolonged prothrombin times.

Carcinogenesis, Mutagenesis: Long-term studies in animals have not been performed to evaluate carcinogenic potential or mutagenesis.

Pregnancy: Teratogenic Effects/Impairment of Fertility — Category B: Reproduction studies have been performed in mice and rats at doses up to 4 times the maximum indicated human dose and have revealed no evidence of impaired fertility or harm to the fetus due to cephradine. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.

Nursing Mothers: Since cephradine is excreted in breast milk during lactation, exercise caution when administering cephradine to a nursing woman.

Pediatric Use: Adequate information is unavailable on the efficacy of b.i.d. regimens in children under nine months of age.

ADVERSE REACTIONS: Untoward reactions are limited essentially to G.I. disturbances and, on occasion, to hypersensitivity phenomena. The latter are more likely to occur in persons who have previously demonstrated hypersensitivity and those with a history of allergy, asthma, hay fever, or urticaria.

(continued on next page)

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(continued)

The following adverse reactions have been reported following use of cephradine: G.I. — Symptoms of pseudomembranous colitis can appear during antibiotic therapy; nausea and vomiting have been reported rarely. Skin and Hypersensitivity Reactions — mild urticaria or skin rash, pruritus, joint pains. Blood — mild transient eosinophilia, leukopenia and neutropenia. Liver — transient mild rise of SGOT, SGPT, and total bilirubin with no evidence of hepatocellular damage. Renal — transitory rises in BUN have been observed in some patients treated with cephalosporins; their frequency increases in patients over 50 years old. In adults for whom serum creatinine determinations were performed, the rise in BUN was not accompanied by a rise in serum creatinine. Others — dizziness, tightness in the chest, and candidal vaginitis.

DOSAGE: Adults — For respiratory tract infections (other than lobar pneumonia) and skin and skin structures infections: 250 mg q. 6 h or 500 mg q. 12 h. For lobar pneumonia: 500 mg q. 6 h or 1 g q. 12 h. For uncomplicated urinary tract infections: 500 mg q. 12 h; for more serious UTI, including prostatitis, 500 mg q. 6 h or 1 g q. 12 h. Severe or chronic infections may require larger doses (up to 1 g q. 6 h.).

Children over 9 months of age — 25 to 50 mg/kg/day in equally divided doses q. 6 or 12 h. For otitis media due to *H. influenzae:* 75 to 100 mg/kg/day in equally divided doses q. 6 or 12 h but not to exceed 4 g/day. Dosage for children should not exceed dosage recommended for adults. There are no adequate data available on efficacy of b.i.d. regimens in children under 9 months of age.

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Radionuclide angiography—1982. . .Indications and usefulness

Richard A Reinhart, MD, Marshfield, Wisconsin

THE TECHNIQUE OF radionuclide angiography is a safe, reliable and noninvasive method of assessing left ventricular function. The reproducibility of the test in determining left ventricular ejection fraction, a sensitive indicator of left ventricular function, and left ventricular wall motion has been repeatedly demonstrated.[1,2] The ability to evaluate left ventricular function during exercise has added another important dimension in the evaluation of patients with known or suspected cardiac disease.[3] The noninvasive nature of this technique has made available a method for follow-up of certain patients in whom it would not be advisable to do repeated studies in the cardiac catheterization laboratory. The test does not replace other established methods that are utilized in the assessment of cardiac function such as electrocardiographic stress testing, echocardiography, and cardiac catheterization but does add important information in the assessment of many cardiac patients.

TECHNIQUE. Radionuclide angiography can be performed either using multiple gated acquisition or first pass techniques.[4,5] Multiple gated acquisition is performed by initially labelling the patient's red blood cells with a radioactive substance, in this case technetium-99M, then scanning the patient's chest with a standard gamma camera to obtain an image of the patient's cardiac blood pool. The gamma camera is interfaced with a computer which enables a collection of data over many cardiac cycles. These data can be utilized to construct a representative cardiac cycle with adequate radioactive counts to perform calculations which will derive left ventricular ejection fraction, end-diastolic and end-systolic volumes of the left ventricle. The data will allow construction of cineangiograms for assessment of left ventricular wall motion. With one injection of approximately 20 mCi of technetium-99M, cardiac imaging can be performed for up to three hours. During this time, studies can be performed at rest in multiple views of the heart, and rest left ventricular ejection fraction and left ventricular wall motion can be compared with exercise. Studies can also be used to evaluate a variety of interventions which have an effect on cardiac function.

Reprint requests to: Richard A Reinhart, MD, Dept of Cardiology, The Marshfield Clinic, 1000 North Oak Ave, Marshfield, Wis 54449 (phone: 715/387-5301). Copyright 1982 by the State Medical Society of Wisconsin.

First pass radionuclide angiography is performed utilizing a bolus injection of technetium-99M into a vein. The radioactive tracer then is detected with a multi-crystal camera as it travels through the right heart, lungs, and into the left heart. Left ventricular function is observed by concentrating on the radioactive tracer as it passes through the left ventricle. Left ventricular ejection fraction can be calculated and cineangiograms can be constructed for evaluation of left ventricular wall motion.

NORMALS. The effect of exercise on left ventricular function has been studied in normal upright subjects.[6] Measurements were made at rest in the sitting position and subjects were then exercised on a bicycle ergometer to 85% of maximum predicted heart rate based on age. The mean left ventricular ejection fraction of this group of normals was 66% with all subjects being above 50%. With exercise, there was an increase in the left ventricular ejection fraction to a mean of 80% with all subjects increasing their left ventricular ejection fraction by at least 5%. Utilizing measurements of cardiac volume, it was shown that stroke volume increased, end systolic volume decreased, and end diastolic volume modestly increased with exercise.

The effect of age on the response of the left ventricle to exercise has also been studied in normal subjects.[7] Age did not appear to influence left ventricular ejection fraction or left ventricular volumes at rest. However, as age increased, during exercise there were diminished amounts of rise in the left ventricular ejection fraction unassociated with differences in end-diastolic volume. It was noted that a significant percentage of subjects over the age of 60 years had a decline in left ventricular ejection fraction with exercise as compared to rest. Left ventricular wall motion abnormalities with exercise occurred in increasing frequency in subjects who were 50 years or older.

The effect of propranolol on left ventricular function in normal young men has been evaluated.[8] The left ventricular ejection fraction at rest and exercise was shown to be less while on propranolol. The data suggested that this difference was due to alterations in the heart rate produced by the propranolol.

Left ventricular function in college athletes has been studied before and after training using radionuclide angiography.[9] It was noted that left ventricular ejection fraction following a period of training was lower at rest

with an associated increase in end-diastolic volume of the left ventricle, slower heart rate, and similar cardiac output. The left ventricular ejection fraction was noted to increase to levels that were attained at exercise before training. The maximum cardiac output that was achieved after training was greater than before training and was felt to be due primarily to an increase in left ventricular end-diastolic volume. Exercise training appears to enhance cardiac performance principally by inducing cardiac dilatation.

INDICATIONS AND USEFULNESS OF RADIONUCLIDE ANGIOGRAPHY. The noninvasive assessment of left ventricular function utilizing radionuclide angiography include evaluation of patients with:

(1) Suspected coronary artery disease when the diagnosis is still in doubt after standard multistage electrocardiographic exercise testing.
(2) Typical angina pectoris in the absence of stress electrocardiographic abnormalities. Alterations of left ventricular function at exercise indicative of significant cornorary artery disease may occur before any ST segment changes or angina.[10]
(3) A positive electrocardiographic stress test without symptoms.
(4) An abnormal resting electrocardiogram that would preclude interpretation of ST segments; *eg,* left bundle branch block or digitalis effect.
(5) Angiographic coronary obstructions of questionable hemodynamic significance.
(6) Previous coronary artery bypass grafting to assess the effects of myocardial revascularization on exercise induced myocardial ischemia.[11,12]
(7) Aortic insufficiency to obtain the earliest possible indication of left ventricular dysfunction to help in the appropriate timing of aortic valve replacement.[13,14]
(8) Cardiomyopathy to obtain an initial assessment of left ventricular function and then to evaluate the efficacy of therapeutic intervention.[15]
(9) Chronic obstructive pulmonary disease when objective assessment of left ventricular function is needed particularly when obscure symptomatology indicative of left ventricular dysfunction is difficult to differentiate from symptoms related to lung disease.[16]
(10) Adriamycin therapy, a situation where serial assessment of left ventricular function is useful to detect cardiac toxicity.[17]

FIGURE 1—Radionuclide angiogram in diastole, right anterior oblique view. LVAL = anterolateral left ventricle, LVA = apical left ventricle, RAO = right anterior oblique, GV = great vessels, RV = right ventricle.

FIGURE 2—Radionuclide angiogram in diastole, left anterior oblique view. GV = great vessels, RV = right ventricle, S = septum, LV = left ventricle, LAO = left anterior oblique.

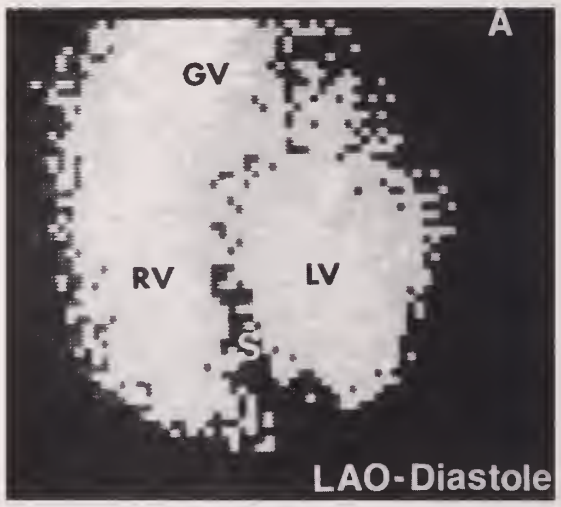
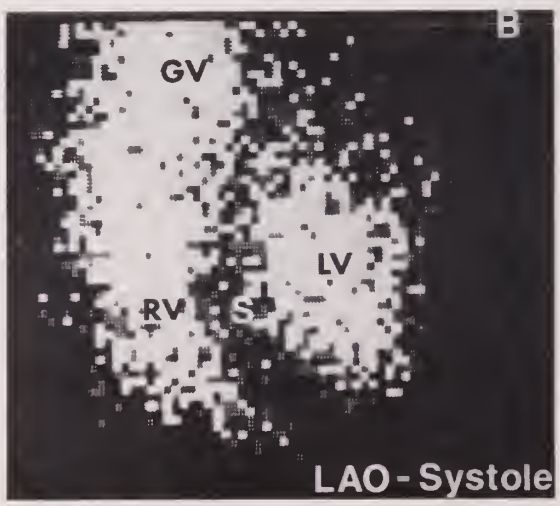


FIGURE 3— Radionuclide angiogram, systole, left anterior oblique view. GV = great vessels, RV = right ventricle, LV = left ventricle, LAO = left anterior oblique.



(11) Suspected left ventricular aneurysm for detection and evaluation of the effects of surgical repair.[18]

In patients with coronary artery disease, the changes that may occur include the development of segmental left ventricular wall motion abnormalities, failure to increase the left ventricular ejection fraction by at least 5% or an actual decline in the left ventricular ejection fraction with exercise as compared to rest. Studies have shown the high degree of sensitivity, specificity and predictive accuracy of radionuclide angiography in detecting coronary artery disease in selected patient populations.[19,20]

SUMMARY. Radionuclide angiography is a safe, accurate, noninvasive test that can be performed to assess left ventricular function. This assessment can be performed not only with the patient at rest but also with the added dimension of stressing the cardiovascular system and observing the response of the left ventricular ejection fraction, left ventricular wall motion and left ventricular volumes. Since the advent of radionuclide angiography, the response of the left ventricle to exercise in both normal and diseased states has been precisely delineated. The effects of coronary artery disease, valvular heart disease, aging, propranolol and cardiovascular conditioning on the left ventricle have all been studied. It can be expected that radionuclide angiography will be in more widespread use in the next several years and that more patients will benefit from the use of this technique.

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ABSTRACTS

Partial hypothalamic insufficiency resulting from herpes simplex encephalitis

ROBERT H CAPLAN, MD, FACP; JAMES E GLASSER, MD; CHARLES A RODMAN, MD; Gundersen Clinic, Ltd, La Crosse, Wis: *Minnesota Med* 65:341-344 (June) 1982

This report describes a 58-year-old man who developed acute adrenal and thyroid insufficiency shortly following a neurologic symptom complex consisting of headache, thalamic pain, and olfactory hallucinations. Endocrine function studies suggested a hypothalamic cause for his glandular failure, and neuroradiologic studies indicated a mass in the right caudate area. Neurologic and hypothyroid symptoms and signs abated, and computed tomography of the brain reverted to normal. Complement fixation studies displayed a rise in herpes simplex (Herpesvirus hominis) antibodies. We suggest that herpes simplex encephalitis may cause endocrine deficiency by involving the hypothalamus. ■

Impact of cisplatin multiagent chemotherapy and total parenteral hyperalimentation on bowel obstruction caused by ovarian cancer

JOSH C TUNCA, MD, University of Wisconsin Center for Health Sciences, Madison, Wis: *Gynec Oncol* 12:219-221, 1981

Seven ovarian cancer patients with complete bowel obstruction were treated with cisplatin combination chemotherapy and total parenteral hyperalimentation. The average time for hyperalimentation was 44.5 days. Six of the seven patients responded to therapy and were discharged from the hospital. This kind of therapeutic modality has value especially for single-agent chemotherapy failure in ovarian cancer with intestinal obstruction. ■

Obstructing intracolonic metastases secondary to fallopian tube adenocarcinoma. . .

Jeffrey T Schouten, MD; James L Weese, MD, and **Dolores A Buchler, MD**
Madison, Wisconsin

ABSTRACT. *A 64-year-old woman developed colonic obstruction two years after receiving therapy for stage IIB fallopian tube carcinoma. The obstruction, which presented as an "apple core" lesion, was caused by intracolonic metastatic fallopian tube carcinoma. The case is reviewed in detail and a review of the literature is presented.*

CASE REPORT. The patient was a 64-year-old caucasian woman whose history dated back to 1974. Following two negative dilatation and currettages for postmenopausal bleeding, a total abdominal hysterectomy and bilateral salpingo-oophorectomy were performed in June 1978. At the time of surgery the left fallopian tube was adherent to the lateral pelvic wall. No tumor was seen in the other abdominal organs. Pathologic studies revealed papillary adenocarcinoma of the left fallopian tube with no tumor present in the ovaries. According to the American College of Obstetricians and Gynecologists' Committee on Terminology, she was staged IIB. A lymphangiogram obtained postoperatively was normal. Postoperatively she was treated with external irradiation (10 MEV photons) to the whole pelvis and periaortic nodes delivering 5,000 rads tumor dose in 30 fractions over 40 days.

Two years later she presented with an acute left colon obstruction. Barium enema revealed an annular constriction in the descending colon compatible with a primary colon carcinoma. She had a normal chest x-ray flim and liver function tests. An emergency transverse loop colostomy was performed on July 2, 1980. Following this, colonoscopy revealed an intrinsic colon lesion; biopsies were negative but a cytologic study was positive for adenocarcinoma. On July 21, 1980, the patient underwent exploratory laparotomy.

Extensive involvement of the omentum with metastatic masses and two areas of colonic involvement (at the hepatic and splenic flexures) was found at the time of surgery. Both of these lesions appeared to be intrinsic colonic lesions (Fig 1). The omentum and involved colon were resected. The patient had an uneventful postoperative course. Pathologic examination revealed metastatic papillary adenocarcinoma involving the colon in two locations, mesenteric and regional lymph nodes and the omentum (Fig 2). She is currently receiving combination chemotherapy (cyclophosphamide [Cytoxan®], hexamethylmelamine, doxorubicin hydrochloride [Adriamycin™] and cisplatin).

This case is unusual in that the colonic lesions were transmural and invaded through the mucosal surface. This made the diagnosis of primary colon carcinoma more likely preoperatively than metastatic fallopian tube carcinoma. However, on pathologic examination both of the colonic lesions had identical histologic appearances with the original tumor removed and irradiated two years previously.

DISCUSSION. Carcinoma of the fallopian tube is a rare malignancy of the female genital tract. Its frequency ranges between 0.31 and 1.11% of all gynecological cancers. The mean age of presentation is 52.[1] There are about 1,000 cases reported in the literature. Most cases are diagnosed as an unexpected finding at the time of surgery. The tumor occurs bilaterally in 26% of the reported cases.[2] The usual physical finding is that of an adnexal mass. The classic triad of symptoms diagnostic for tubal carcinoma, pain, menorrhagia, and leukorrhea is rarely seen. Rather, presenting symptoms tend to be nonspecific. Cervical cytology is of little help in establishing the diagnosis. Sedlis reported that the cytologic smears were positive in 60% of the 17% of their patients who had the procedure performed.[1] The histology is similar to serous papillary carcinomas of the ovary and one needs to see the tumor arise in the tubal epithelium to be assured that it is not an ovarian malignancy.

The staging system recommended by the American College of Obstetricians and Gynecologists' Committee on Terminology is shown in Table 1.[6]

The mode of spread, direct extension, is similar to ovarian carcinomas. It has been reported that there is a higher incidence of nodal metastases with fallopian tube carcinomas than in ovarian carcinomas. Therefore, if the diagnosis of fallopian tube is suspected preoperatively, a lymphangiogram may be useful. In a

From the Departments of Surgery, Human Oncology, and Obstetrics and Gynecology, University of Wisconsin, Madison. Reprint requests to: James L Weese, MD, Dept of Surgery, University of Wisconsin, 600 Highland Ave, Madison, Wis 53792. Copyright 1982 by the State Medical Society of Wisconsin.

FIGURE 1—Surgical specimen showing penetration of metastatic tumor through the colon mucosa.

review by Sedlis, the most common sites of metastasis are peritoneum, ovaries, uterus, and intestine.[3]

The three-year survival figures reported based on literature reviews are:

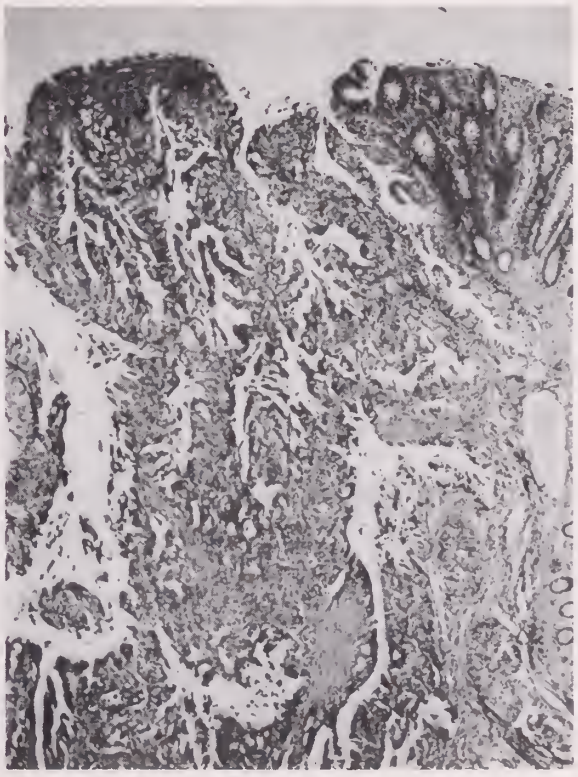
Stage I	60%	Stage III	10%
Stage II	40%	Stage IV	0%

Most of these data were collected prior to the use of chemotherapy which, in advanced stages, may prolong survival and improve cure rates. The overall five-year survival rate is reported to be 38%.[4]

Table 1—*Staging system for carcinoma of the fallopian tube*

Stage	Operative Findings
0	Carcinoma in epithelium only
I	Carcinoma only involving the fallopian tube
IA	Carcinoma confined to one fallopian tube; no ascites
IB	Carcinoma involving both tubes only; no ascites
IC	Carcinoma in one or both tubes; ascites present
II	Carcinoma involving organs in the true pelvis
IIA	Carcinoma involving only the uterus, or ovaries, or both
IIB	Carcinoma extends to organs or tissues within the true pelvis
III	Metastases outside of the true pelvis, but within the peritoneal cavity
IV	Metastases outside of the peritoneal cavity

FIGURE 2—Histologic view of pathological specimen. Note the transition from normal colonic epithelium to the papillary adenocarcinoma (20 ×).



Treatment is primarily surgical, based on guidelines established for ovarian carcinoma. "Debulking" has been recommended to improve the response to chemotherapy.[1] Due to the high incidence of bilaterality, unilateral excision is not recommended. Radiotherapy has been advocated to treat residual pelvic disease.[5] However, due to the poor prognosis of stage II disease, chemotherapy is advocated as adjuvant or advanced therapy. The relative role of chemotherapy versus radiotherapy to treat metastatic tumor within the true pelvis remains unsettled.

This case is reported as an unusual cause of acute colonic obstruction, as well as an unusual clinical course for fallopian tube adenocarcinoma, presenting with intrinsic colon metastases.

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ABSTRACTS

Public policy and innovation: the case of pharmaceuticals

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Technovation 1:157-189, 1982

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The pharmaceutical industry has been subject in recent years to an expanding set of regulatory constraints and related policy actions adversely affecting its level of innovation. The experiences of this industry provides some important insights for recent national policy discussions on declining innovation in the US and the need for economic "revitalization." The first section of the paper considers the societal benefits resulting from new drug therapies and other kinds of industrial innovation. An analysis of the basic characteristics of the R and D investment decision is then undertaken along with recent trends in various determinant factors. The last half of the paper evaluates the effects of government regulatory, patent, and reimbursement policies on R and D incentives and the level of pharmaceutical innovation. The paper concludes with several recommendations for policy changes to improve the incentives for industrial innovation in this and related high technology industries.

Editor's note: This paper documents the importance of industrial innovation by contrasting the performance of various research and non-research sectors in terms of their long-term output growth, relative price changes, productivity, balance of trade and profitability. It also provides a case analysis of the central role of new pharmaceuticals in the declining mortality and morbidity rates from particular diseases. The second half of the paper shows how evolving government regulatory, patent, and reimbursement policies over the past two decades, although well intended, have had a significant adverse impact on the drug innovational process. The concluding section evaluates a number of public policy reforms that have been put forth recently for improving the incentives for pharmaceutical innovation.

This study combines two major areas of current research interest at the Center for the Study of Business Regulation: (1) government regulation involving risk management and (2) industrial innovation. Since its establishment at Duke University in 1978, the Center has performed original research on regulatory problems confronting the economy and has actively exchanged ideas and research results with policymakers, business managers, academicians, and students. It is supported by grants from government, industry, and alumni.

The author and publisher especially wish to acknowledge Hoffmann-La Roche for supporting the research on the comparative performance of innovative industries and for making possible the broader dissemination of reprints. The research analyses of regulation and innovation were supported by grants from the National Science Foundation, the National Academy of Engineering, the Federal Trade Commission, and the Center's general research program.

Reprints are available upon request to: W Kip Viscusi, Director, The Fuqua School of Business, Center for the Study of Business Regulation, Duke University, Durham, NC 27706. ■

The management of ovarian-cancer-caused bowel obstruction

JOSH C TUNCA, MD; DOLORES A BUCHLER, MD; EBERHARD A MACK, MD; FRANCIS F RUZICKA, MD; JOHN J CROWLEY, PhD; WILLIAM F CARR, AB, University of Wisconsin Center for Health Sciences, Madison, Wis:

Gynec Oncol 12:186-192, 1981

The records of 518 patients with ovarian cancer between 1969 and 1977 were retrospectively analyzed. During the course of their disease, 127 patients developed intestinal obstruction. Obstructions occurred in 17 (13.9%) of stage I patients, 17 (16.8%) of stage II patients, 72 (30.0%) of stage III patients, 20 (36.4%) of stage IV patients, and in one of the three patients whose initial staging was unknown. At advanced stages, patients developed intestinal obstruction more quickly. Patients deemed terminal and thus inoperable survived an average of two months. Those treated surgically for these obstructions survived an average of seven months. Colostomy patients lived for 6.6 months. The degree of obstruction, partial or complete, was not significantly related to survival. The median time of survival for all patients with obstruction was 112 days. ■

Unusual rhabdomyoma

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Steven Guiseffi, MD
Mark Malangoni, MD
Anthony Montag, MD
Lawrence Clowry, MD

Milwaukee, Wisconsin

ABSTRACT. *A case of a rhabdomyoma of the abdominal wall in a 37-year-old woman is presented. The histological and electronmicroscopic characteristics of the tumor are discussed and compared with the ones reported in the literature. This case probably constitutes a variation within the actual classification. Its location is extremely unusual.*

RHABDOMYOMA IS ONE of the least common tumors of the human body, originating from skeletal muscle or myocardium and composed of striated muscle cells showing various degrees of differentiation. The cardiac type is by far the most common and it is often associated with phakomatoses such as neurofibromatosis and tuberous sclerosis. The rare extracardiac variety has been encountered most often in the head and neck area with very few cases in different locations such as axilla,[1] thoracic wall,[2,3] stomach,[4] uterus,[5] vulva,[1] vagina[6,7,8,9,10] and mediastinum.[11] We are reporting a rhabdomyoma of the abdominal wall which, to the best of our knowledge, has a very unusual site of presentation and morphology.

CASE REPORT. A 37-year-old, black woman was admitted to the Milwaukee County General Hospital for evaluation of an enlarging mass in the right lower abdominal wall. This was intially noted three years prior to admission, and was infrequently associated with sharp, nonradiating pain. Other than a tendency toward recurring upper respiratory infections, the patient was healthy. A medical history was noncontributory. Physical examination was normal, except for a firm 8 × 8cm mass in the right lower abdominal wall directly cephalad to the anterior superior iliac spine. The margins were indistinct and the mass became less prominent on contraction of the abdominal musculature. Chest x-ray films and laboratory tests, including SMA-6, SMA-12, complete blood cell count, and urinalysis, were within normal ranges except for an hematocrit reading of 37%. Abdominal computerized tomographic (CT) scan revealed an ovoid thickening of the internal oblique muscle, extending above and slightly below the iliac crest for a total distance of 10 cm (Fig 1). At surgery the tumor was totally excised by partial resection of the internal oblique and transversus abdominus muscles. The abdominal wall was reconstructed with Marlex® mesh.

Pathological Findings. The surgical specimen consisted of a well-circumscribed, large mass of muscle-like tissue compressing the surrounding normal muscle and measuring 13 × 7 × 4cm. Hematoxylin and eosin stained sections showed the tumor to be composed of slightly irregular muscle fibers with disorderly arrangement showing peripheral nuclei and cytoplasmic cross striations, indistinguishable from normal skeletal muscle. There was no mitotic activity. The fibers were occasionally separated by scanty fibrofatty stroma. The tumor was sharply demarcated from the adjacent normal muscle by a thin deli-

FIGURE 1—Computerized tomographic (CT) scan of lower abdomen showing dense homogeneous thickening of the right internal oblique muscle demarcated by fat planes.

From the Departments of Pathology and Surgery, The Medical College of Wisconsin, Milwaukee. Reprint requests to: Gonzalo Madiedo, MD, Department of Pathology, MCW, 8700 West Wisconsin Ave, Milwaukee, Wis 53226 (phone: 414/257-6201). Copyright 1982 by the State Medical Society of Wisconsin.

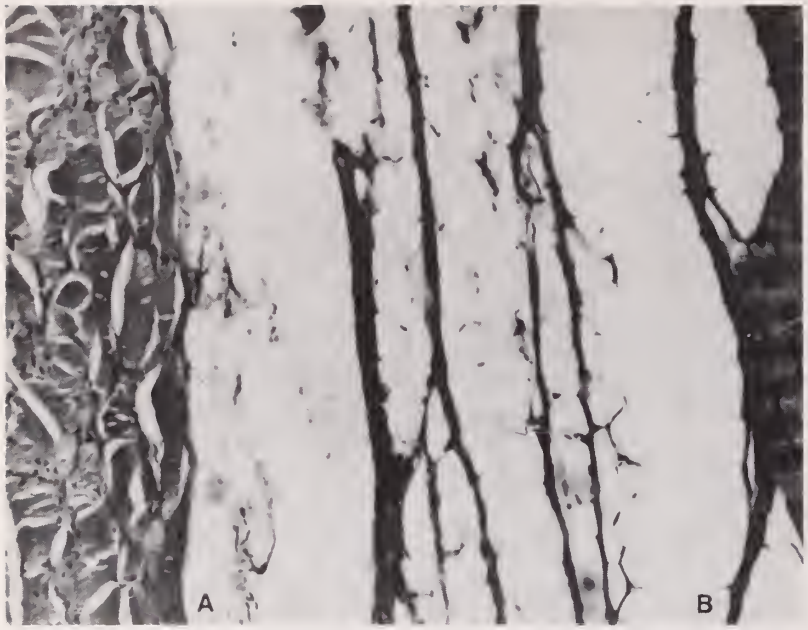

FIGURE 2—Tumor (A) and normal skeletal muscle (B) separated by delicate fibrocollagenous and adipose tissue. Hematoxylin and eosin, X 40.

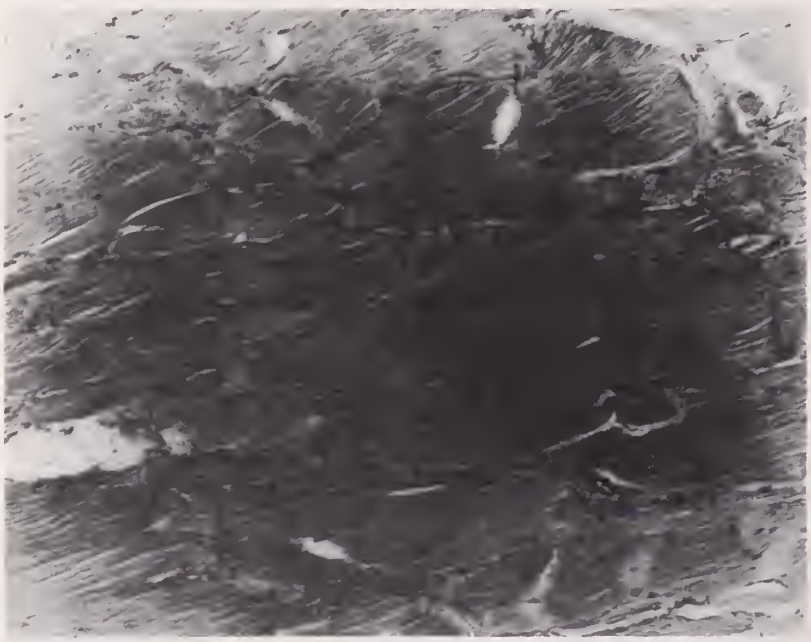

FIGURE 3—Tumor composed by mature muscle fibers showing disorderly arrangement. Hematoxylin and eosin, X 100.

cate fibrocollagenous capsule (Fig 2). There was no evidence of invasion or reaction of any kind in the adjacent normal muscle (Figs 3 & 4). The electron microscopic study revealed the fibers to have an internal organization identical with normal skeletal muscle (Fig 5).

DISCUSSION. Extracardiac rhabdomyomas are classified into fetal and adult type [12] and are considered to be different tumors.[2] The fetal variety characteristically is composed of skeletal muscle fibers with different degrees of maturation haphazardly arranged, mixed with undifferentiated mesenchymal cells.[2] The adult type is generally formed by more mature, large, round, polygonal and occasional "strap" and "ribbon" cells with one or multiple nuclei, most of them peripherally located; the cells frequently contain irregular cytoplasmic vacuoles and occasional distinct cross striations.[13,14,15] Electron microscopic studies have shown the ultrastructure of the adult type rhabdomyoma to be abnormal with a haphazard distribution of the myofibrils which are branched and rudimentary, with occasional A and I bands and prominent Z bands.[13,15]

The histological characteristic and ultrastructure of the tumor reported here make it unique and different from the majority of the adult type extracardiac rhabdomyomas described in the literature. Its morphology is comparable only to a parapharyngeal tumor reported by Shapiro[16] that was later classified by Di Sant' Agnese as a hamartoma.[17]

The lesion presented here could be classified as an example of muscular hypertrophy with or without hyperplasia or as a hamartoma or as a benign skeletal muscle neoplasm. Accepting that skeletal muscle in vivo does not have the capacity for hyperplastic growth and that simple hypertrophy is highly unlikely considering its location and gross and histological characteristics, we are left with the other two alternatives. The possibility of hamartoma can not be completely ruled out, although it is unlikely considering certain characteristics of the tumor such as the exaggerated expansile growth and the compression of the surrounding normal structures. Therefore the only remaining possibility is that this lesion is a benign muscle neoplasm, that is, a rhabdomyoma. It is of interest that its morphology differs considerably from other benign skeletal muscle tumors previously reported, raising the possibility that it represents a variation within the existing classification of extracardiac rhabdomyomas. Another unusual feature of this case is the site of presentation. We are not aware of any other case of rhabdomyoma originating in the abdominal wall.

Rhabdomyomas are successfully treated by local surgical excision. Of 29 cases of the adult type there are only 3 reported recurrences,[17] and these are probably due to incom-

plete excision of the tumor. In the present case the tumor mass was entirely excised to include a margin of adjacent normal muscle and fascia. The patient is known to be doing well seven months after operation.

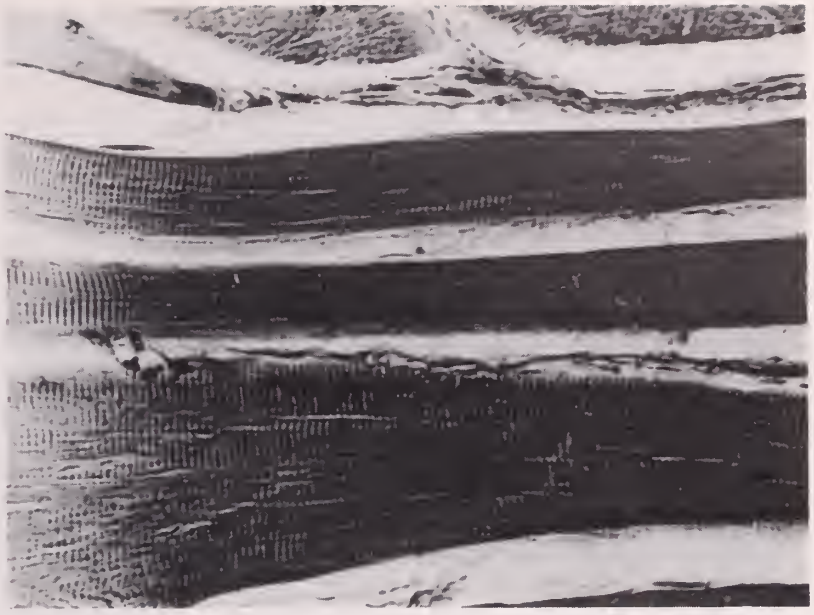

FIGURE 5—Electron micrograph of the tumor in longitudinal section showing normal A, I and Z bands. X 13,600.

FIGURE 4—Higher magnification of Figure 2 showing distinct cross striation of the myofibrils. Hematoxylin and eosin, X 250.

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ABSTRACT

Adult rhabdomyoma

Ultrastructure and immunochemistry

THOMAS F C S WARNER, MD MSc; WILLIAM GOELL, MS; MIRMALA SUNDHARADAS, MD; and VICTOR S FALK, MD, Dept of Pathology, University of Wisconsin Medical School, Madison, Wis (TFCSW, WG); Mercy Hospital, Janesville, Wis (MS); and Dept of Surgery, Edgerton Clinic, Edgerton, Wis (VSF): *Arch Pathol Lab Med* 105:608-611 (Nov) 1981.

THE AUTHORS REPORTED a case of adult rhabdomyoma, a benign, highly differentiated tumor of skeletal muscle. The tumor occurred in the submandibular area of a 66-year-old woman. The ultrastructural features of the adult rhabdomyoma were studied by electron microscopy. Few have been studied by this technique before. The authors concluded that the adult rhabdomyoma might, in many respects, be regarded as the most differentiated neoplasm of striated muscle origin. Ultrastructural features were described that had not been previously demonstrated in other tumors of striated muscle origin. Transverse tubules and triads in addition to myofilaments in the rhabdomyoma were observed. Several types of muscle cells were present, and myoglobin was also detected in the tumor.—VSF ■

Abstracts

The following abstracts are from papers presented at the **Wisconsin Orthopaedic Society** meeting, November 13, 1981 in Oconomowoc, Wisconsin. The presentor's name is shown in boldface type. Thomas A Lange, MD of Madison served as the ad hoc editor for these abstracts.

The fate of ceramic calcium phosphate blocks placed into the intervertebral disc space in mature rabbits

Thomas Flatley, MD, Kenneth Lynch, MD
and **Mark Benson, MD**, Milwaukee, Wisconsin

Ceramic blocks with 50% porosity and pore size of 500 microns were implanted into the intervertebral disc space of the lumbar spine in 26 mature New Zealand white rabbits. A posterolateral approach was used for implantation under Ketamine anesthesia. Animals were sacrificed at 3, 6, 8, 12, and 24 weeks. Controls, which had curettement of disc space without implantation of ceramic, were sacrificed at 3, 8, and 12 weeks.

The controls showed only fibrous ingrowth at 12 weeks.

At 3 weeks there was immature bone formed in the pores of the ceramic. At 12 weeks the transformation of lamellar bone had taken place and the intervertebral disc space was bridged.

In no instance was there a fibrous interspace between the ceramic and new bone. There was no evidence of an inflammatory reaction, and there was no early resorption of ceramic. Further biomechanical studies must be done to determine the possibility of the use of ceramic in human beings as an adjunct to autogenous bone graft. ■

The role of arthroscopy in evaluation of high tibial osteotomies

James S Keene, MD and **James R Dyreby, MD**
Madison, Wisconsin

Sixty-six consecutive knees (56 patients) were arthroscopically, radiographically, and clinically evaluated prior to high tibial valgus osteotomies for osteoarthritis of the knee. Fifty-four knees (49 patients) returned for evaluation at a minimum of two years. Twenty-one of the 54 knees have been followed for at least three years.

The knee rating scales of Kettlecamp and Insall were completed for each patient prior to the osteotomy and at the two-year and three-year evaluations. An arthroscopic knee rating scale was developed so that the arthroscopic findings and the clinical results could be numerically compared. When we compared the preosteotomy arthroscopic ratings with the radiographic alignments and knee scores at two years and three years, we found that: (1) bi- or tri-compartmental osteoarthritis of the knee [including exposed bone] was not a contraindication for high tibial valgus osteotomy; (2) achieving and maintaining 5-13° valgus alignment [documented by weight-bearing radiographs] was associated with good or excellent results regardless of the status of the lateral compartment, patellofemoral joint, or cruciate ligament; and (3) preosteotomy arthroscopic findings appear to be of limited predictive value in the selection of patients for high tibial valgus osteotomy. ■

Transient avascular insult in the pediatric hip

Jeffrey L Minikel, MD, Milwaukee, Wisconsin

Six patients were seen with various hip pathologies: two with transient synovitis, one septic arthritis and three transepiphyseal fractures. Each patient had a bone scan shortly after admission, which revealed a "cold" capital femoral epiphysis. Following treatment consisting of either traction, aspiration, arthroscopy or ORIF, repeat bone scan revealed radionuclide uptake in the capital femoral epiphysis. Follow-up x-ray films and examinations revealed that avascular necrosis had not occurred.

There are two types of avascular insult: the invisible and the potentially reversible. The potentially reversible avascular insult can be subdivided into two groups. Group I is secondary to an elevated intracapsular pressure and resultant tamponade of blood supply to the capital femoral epiphysis. Group II is secondary to a mechanical compression, breaking, stretching or torsion of the blood supply to the capital femoral epiphysis.

We believe there is a "golden period" in which, even though the osteocyte is ischemic, it remains viable. If revascularization occurs prior to osteocyte death, avascular necrosis will not ensue. Attempt at early recognition of the potentially reversible avascular insult should be made utilizing bone scans. Once recognized, attempts at revascularization prior to osteocyte death should be pursued to prevent avascular necrosis. ■

Veterans Administration experience with total hip revisions: 1969-1981

James A Johnson, MD, Milwaukee, Wisconsin

We reviewed all of the total hip revisions done at the Veterans Administration Medical Center in Wood, Wisconsin, for major complications. This was a retrospective chart review and included 49 revisions done on 41 patients. Excisional arthroplasties were excluded from the study. Statistics for patient age and diagnosis, indications for surgery, and surgical technique were examined; and major complications were defined as deep venous thrombosis, fracture, dislocation, infection, and miscellaneous. The follow-up period ranged from six months to nine years.

We found significantly higher complication rates in the revised hips than in the primary replacements. There was a 12.2 percent incidence of deep venous thrombosis, an 18.4 percent incidence of fracture, a 14.3 percent incidence of dislocation, and a 6.1 percent incidence of infection in this study group. The overall rate of at least one major complication in this group was 38.8 percent. These findings were compared with other statistics found in the literature.

This review led us to several conclusions. The Bechtol Series I prosthesis which was used for the majority of primary replacements is not a good prosthesis and had an unacceptably high rate of failure.

We feel that the creation of a femoral shaft window to facilitate cement removal should be avoided since it is associated with greater incidence of femoral fracture. Furthermore, we feel that a long-stemmed femoral component should be used for revisions, particularly if a cortical window is made or there is resorption at the tip of the femoral component. Routine antibiotic prophylaxis and some form of postoperative anticoagulation are especially important with this procedure. Finally, the use of non-cemented femoral prostheses may significantly reduce the morbidity associated with this procedure. ■

Surface replacement arthroplasty of the hip

John K Konkel, MD and Robert C Zuege, MD
Milwaukee, Wisconsin

Fifty Indiana and Wagner surface replacement arthroplasties done through an anterior approach from August 1978 to August 1980 were reviewed. The average age at operation was 52 years and average follow-up was 23 months with a minimum follow-up of one year.

Twenty-nine patients had the diagnosis of osteoarthritis; nine had avascular necrosis; six had rheumatoid arthritis; four had hip dysplasia; one, post sepsis and one, failed cup arthroplasty. One patient was lost to follow-up.

Our indications, operative technique and rehabilitation program are discussed.

The hips were rated using the Hospital for Special Surgery system. The postoperative ratings for pain, walking, and function average 8.9, 9.1, and 9.0 respectively, all in the good-to-excellent range. The arc of flexion improved 24° and arc of rotation 21°. There were no femoral neck fractures, dislocations, deep infections, or severe ectopic bone formation. There have been no revisions, but two hips have been rated unsatisfactory and are suspected of loosening.

The six patients with moderate ectopic calcification were analyzed separately and found to have a similar range-of-motion when compared to the whole group. No significant differences could be found between the two types of prostheses.

We are encouraged by the good, short-term results in this series and feel that they are comparable to those of conventional total hip replacement. ■

Ender nailing of the tibia; a preliminary report

Thomas S Werbie, MD and Roger P Johnson, MD
Milwaukee, Wisconsin

Twenty-five selected fractures of the tibial shaft were treated by closed Ender nailing. The patients fell into two groups, namely, 12 tibias were nailed primarily and 13 had secondary nailings after other methods failed to maintain an acceptable reduction. Fourteen tibias were opened and 10 patients had additional significant skeletal injuries.

Twenty patients had two antegrade nails inserted proximally, one each medially and laterally. Five patients with fractures of the distal one-third underwent retrograde nailing from below. Most tibias were additionally treated with SLWCs until clinically united; however, several selected fractures were treated without a cast.

Overall healing time was 21.5 weeks with average time in plaster of 8.2 weeks. Fractures nailed primarily healed in 16.2 weeks (r = 8-52). Fractures nailed secondarily with an average delay of 8 weeks from injury to nailing healed in 27.6 weeks.

Two asymptomatic patients required bone grafting to achieve union. Two patients developed purulent drainage from their fracture sites several weeks after they were clinically healed and responded to intravenous antibiotics.

It is concluded that: (1) healing time in patients treated with Ender nails is comparable to other methods of fixation; (2) it is a simple procedure to perform; (3) the nails provide immediate stabilization, including excellent rotatory stability; (4) it is a low risk procedure; and, finally, (5) it can provide distal fixation by introducing the nails from below, an option that does not exist with other intramedullary devices. ■

Thigh compartment syndrome in a college hockey player

Ernest A Pellegrino, MD, Madison, Wisconsin

The compartment syndrome develops when the tissue pressure within a muscle compartment is excessive and limits the perfusion of the contents of the compartment resulting in progressive ischemia. The hallmarks of the condition include intense pain unresponsive to parenteral analgesics, decreased sensation in the distribution of the sensory nerves passing through the compartment, weakness of the muscles in the compartment, marked pain with passive movement of the involved muscles, and a swollen, tense, and tender compartment.

A case of a college athlete, who was struck in the thigh by a competitor's knee, was described in which all of the above clinical criteria were seen. In addition, measurement of his thigh tissue pressure was 70 mm Hg compared to the normal tissue pressure of under 10 mm Hg. Tissue pressure exceeding 40 mm Hg by the method described by Whitesides should be decompressed surgically by an extensive open fasciotomy as was done in the author's case. Uniformly good results can be anticipated if done early before irreversible tissue death occurs. In animals tissue death occurs as early as eight hours and in humans this appears to depend on the degree as well as the length of time of ischemia and individual tolerance as well. The author emphasized the need to remember that this condition can occur in other sites besides the commonly described forearm and lower leg compartment syndromes. ■

Osteitis pubis in athletes

William G Clancy Jr, MD, **Arnold N Rosenthal, MD** and James S Keene, MD, Madison, Wisconsin

Osteitis pubis, also known as pubis symphysitis, is defined as an inflammatory process involving the pubic symphysis. The majority of early clinical reports arose from the urological literature and were often associated with genitourinary surgery. Osteitis pubis has recently been recognized and described in athletes. Past reports have not stressed the common presenting complaint of groin pain and adductor pain.

Eleven cases of osteitis pubis have been seen at the University of Wisconsin Sports Medicine Clinic between 1978 and 1981. The average age of the patients was 25 years with a range of 18 to 42 years.

All of the athletes were male, four of seven were long distance runners, two were football players, and one an intercollegiate swimmer. The chief complaint was adductor muscle pain with the duration of symptoms from three weeks to two years. None of the patients related any specific mechanism of injury or trauma. All patients noted the onset and recurrence of symptoms after strenuous activities which were relieved with rest. All patients denied any history of urinary symptoms.

Physical examination revealed tenderness over the pubic symphysis as well as tightness of the adductor muscle group.

Radiographic findings included irregularity of the pubic symphysis as well as resorptive changes with widening of the symphysis. Two of the patients with long-standing complaints were noted to have sclerotic changes in the area of the pubic symphysis. Four patients had the diagnosis confirmed by a radionuclide bone scan.

The patients in this series were treated with rest, anti-inflammatory medications, and adductor muscle group stretching exercises. Three patients received a steroid injection into the area of the pubic symphysis at the time of presentation. Patients resumed training when there was no longer any localized tenderness and situps could be performed without pain.

Resolution of symptoms in six of seven treated patients occurred within 16 to 24 weeks.

The etiology of this condition remains unknown. We feel the high incidence of groin pain in these patients is secondary to adductor group overuse in an attempt to minimize motion of the pelvis.

Differential diagnoses should include femoral neck stress fractures, stress fractures of the pubic rami, muscle strains, and chronic prostatitis. ■

Anterior cruciate ligament entrapment: a cause of mechanical derangement of the knee

Thomas E Anderson, MD and William G Clancy Jr, MD
Madison, Wisconsin

Six patients with known anterior cruciate ligament tears who lacked full extension and had diffuse anterior knee pain with effusion were presented.

The signs and symptoms persisted up to four months from the time of the injury. In each patient the preoperative arthrogram was considered negative for meniscus pathology.

At arthroscopy a portion of the anterior cruciate ligament was found to be entrapped in either the medial (5) or lateral (1) compartment and blocking full extension. In each case the entrapped remnant was attached tibially.

Arthroscopic excision of the cruciate remnant allowed full extension of the knee, relieved the pain, and dissipated the effusion in each case.

These signs and symptoms when present in a symptomatically stable anterior cruciate deficient (Lachman positive, pivot-shift negative) knee, should alert the physician to the possibility of anterior cruciate ligament entrapment. This entrapment can be readily treated at the time of arthroscopy. ■

Computer modeling of the biceps femoris tendon transfer

Rajesh G Narechania, MS and William G Clancy Jr, MD
Madison, Wisconsin

The biceps femoris tendon transfer was designed to resist the abnormal rotation and anterior lateral subluxation of the tibia and to increase the rotatory efficiency and the anterior-lateral stability of the knee.

The transfer of the biceps femoris tendon consists of placement of the tendon under the fibular collateral ligament and attachment just inferior to Gerde's tubercle. A biomechanical analysis of the transfer was performed by computer modeling.

Our results demonstrated that due to the new insertion position of the tendon, the resting length of the muscle increases. This enables the muscle to act as a stronger external rotator and adds a component in the posterior direction that resists anterior subluxation. In effect the vector increases in the posterior lateral direction.

In addition the results also show that the biceps tendon before and after the transplantation have a marked functional dependence on the position of the knee in flexion and internal rotation. ■

Anti-inflammatory medications in sports medicine: a double-blind study comparing fenoprofen calcium and oxyphenbutazone

Gary N Guten, MD, Milwaukee, Wisconsin

A prospective, double-blind study was conducted to compare the efficacy and safety of fenoprofen calcium with that of oxyphenbutazone in patients with sports-derived acute inflammatory soft-tissue injuries.

Materials and Methods. The 121 patients enrolled had persistent or acute inflammatory soft-tissue injuries resulting from sports or recreational activity.

Each enrolled patient was instructed to take two capsules, four times a day for seven days. Patients were randomly assigned to either the fenoprofen or oxyphenbutazone groups. For fenoprofen the daily dose equaled 2400 mg, and for oxyphenbutazone, 400 mg. No adjustment of dosage was permitted. If a patient required dose adjustment, he or she was excluded from the study.

Results. Of the 121 patients enrolled in the study, 108 (54 patients with each drug) completed the study according to protocol and were included in calculations of drug efficacy. Most were men (79%) and the largest group was in the 20- to 29-year age group.

There was no significant difference in perceived efficacy rating by either physician or patient between the two drug groups.

There were no significant differences between the two drugs as measured by improvement in clinical parameters—pain at rest, pain with motion, and tenderness on pressure.

Summary. The comparative efficacy and safety of fenoprofen calcium and oxyphenbutazone, representative nonsteroidal anti-inflammatory analgesic agents, were evaluated in a double-blind study of 121 patients with sports-derived inflammatory soft-tissue injuries. During seven days of treatment both drugs produced equal improvement in clinical pain and inflammation parameters. Adverse experiences were more common with fenoprofen ($p = 0.064$), although most were mild and were related to the gastrointestinal tract. The two drugs appear to be equally effective for the conservative management of sports injuries. ■

Posterior cruciate ligament reconstruction: preliminary report of a new technique

William G Clancy Jr, MD, Madison, Wisconsin

Posterior cruciate injuries, although thought to be uncommon, can lead to significant sequelae if not recognized and treated. Recently, Trillat and Kennedy have reported on their long-term follow-up of nonoperative treatment of isolated and combined posterior cruciate injuries. Trillat noted that a significant number developed disabling symptoms and degenerative changes approximately six years post injury. Kennedy noted that 25 of 57 patients developed significant degenerative changes within an average of 61 months.

The reports of primary repair of midsubstance ligament injury, as well as the results of the numerous static procedures for chronic posterior cruciate insufficiency, have been variable.

In order to insure more consistent results in the acute and chronic cases of posterior cruciate insufficiency a new procedure was developed. After preliminary investigations in Rhesus monkeys utilizing microangiography, histology and tensile testing, this procedure utilizing the medial one-third patella bone, patella tendon and tibial bone as a free graft was performed in 36 patients over the past three years. Twenty patients have been followed sufficiently to allow for a preliminary report and have been divided into two groups based on whether they were acute or chronic injuries. Group I consisted of 11 patients, 10 males and 1 female, with an average age of 24 years with a range of 12 to 32 years, who underwent repair of an acute interstitial midsubstance posterior cruciate ligament rupture and patella tendon free graft reconstruc-

tion. The average follow-up for this group was 27.5 months (15-42 months).

Group II consisted of nine male patients, with an average age of 25 years with a range of 18 to 38 years who had symptoms of chronic posterior cruciate ligament disability and instability and who underwent posterior cruciate ligament reconstruction with patella tendon free graft. The average follow-up for this group was 19 months (13-39 months).

At follow-up examination all 11 patients in group I were graded good to excellent. All had returned to previous athletic activities without any episodes of pain, effusions or instability. The posterior drawer was absent in four, trace positive in four and 1+ in three.

Of the nine patients in group II, seven patients were graded good to excellent and two were graded fair. Seven of the nine patients returned to their previous athletic activities without episodes of effusion or instability. The posterior drawer test was trace in four and 1+ in the remaining five.

The patellar tendon free graft substitute for posterior cruciate ligament insufficiency has been found to offer excellent static and functional stability during this preliminary study period. ■

Interested physicians wishing more information may contact Thomas A Lange, MD, Department of Surgery (Orthopedics), University of Wisconsin Hospital and Clinics, 600 Highland Avenue, Madison, Wisconsin 53792 (phone: 608/263-9138); or D Scott Sellinger, MD, Secretary, Wisconsin Orthopaedic Society, 1226 North 8th Street, Sheboygan, Wisconsin 53081 (phone: 414/458-3791). Copyright 1982 by the State Medical Society of Wisconsin.

Stress x-ray films of the knee and their surgical correlation

Clarence R Hart, MD, Lake Geneva, Wisconsin

O'Donoghue,[1] in describing his "unhappy triad" knee injuries in 1950, rated the medial instability +, ++, +++, and subsequently Godschall[2] used the terminology, grades I through IV, to illustrate the instability demonstrable on abduction stress testing. This clinical stress is subjective and imprecise leading to variable interpretation.

In 1969 Oullett[3] pointed out no more than 0.4 mm difference on valgus stressing occurs in completely normal knees. In 1973 Larsen[4] used stress x-ray films on injured knees that demonstrated 10 to 13.5 mm of opening. More recently Jacobsen[5,6] demonstrated that a difference of greater than 2 mm between the two knees indicated rupture of the deep medial ligaments of the knee. Since 1970 we have used a method similar to that of Jacobsen. After infiltrating local anesthesia with the thighs bound together and the knees at 20 degrees flexion, the ankles are abducted with a valgus force at the time of the x-ray. We have used this gonylaxometry technique to study comparative valgus stress gaping in the normal knee and the acutely injured knee. Significant tears of the anterior cruciate, medial-collateral ligament, posterior capsule, and posterior cruciate ligament could be present with as little as 3 mm greater gap seen in injured knees compared to the normal or "control" knee.

A second group of patients were then studied from one to four years after operative repair of the involved structures. Significant reduction in the medial opening could be demonstrated from the preoperative findings.

We submit that anymore than 3 mm opening on the medial side of an acutely injured knee, may indicate significant ligamentous damage within the knee. Gonylaxometry provides a reproducible "quantitive" evaluation of medial instability of the knee.

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The Physician's Sleep Glossary

Some common sleep laboratory terms

poly•som•no•graph. An instrument which simultaneously records by electrodes physiological variables during sleep—for example, brain activity (EEG), eye movements (EOG), muscle tonus (EMG) and other electrophysiological variables. These readings indicate precisely when patients fall asleep, how many wake periods they experience, the quality of sleep and the duration of sleep.

sleep la•ten•cy. The period of time measured from "lights out," or bedtime, to the commencement or onset of sleep.

wake time af•ter sleep on•set. Intervals of time spent awake between onset of sleep and the end of the sleep period. The polysomnograph registers the length and frequency of the intervals.

to•tal sleep time. The amount of time actually spent in sleeping. This is estimated by subtracting wake times from the period encompassed by the onset and the termination of sleep.[1]

REM/NREM. 1. REM, or rapid eye movement, sleep is "active"—characterized by increased metabolic rates, elevated temperature and arousal-type EEG patterns. 2. NREM, or non-rapid eye movement, sleep represents "quiet" sleep stages. There are four distinct stages of NREM sleep.[2]

re•bound in•som•nia. A statistically significant worsening of sleep compared to baseline on the nights immediately following discontinuation of sleep medication.[3]

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Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

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WISPAC hears from gubernatorial candidates

At least the five candidates running for Governor of Wisconsin could agree on one thing August 20-21, when the Wisconsin Physicians' Political Action Committee (WISPAC) interviewed each at SMS offices in Madison. All five agreed that the major health care issue facing Wisconsin was indeed Medicaid costs; however, their proposals for fixing the program varied.

Republican candidate Terry Kohler thought that the Medicaid problem and the whole health care cost problem is one of perception. "We must make the user of health care realize that it is not a 'free good,'" he said. "Misuse of medical services results when this attitude prevails."

His Republican counterpart, Lowell Jackson, pointed out that the problem lies in the state failing to use traditional long-range planning in the health care system. "We have a system that has no built-in market regulator; one that is built on competition by service, and not by price;" Jackson added that government mandate is no solution. "The 'preferable solution,' " he said, "is to have the people involved in health care try to change it." He did not rule out the use of copayments for the categorically needy.

On the Democratic side of the aisle, Tony Earl said that Medicaid costs must be a major concern of the next governor. "We must insure that Medicaid does not cover more than a regulator insurance program would cover. Over the last few years a couple provider groups such as chiropractors and podiatrists have been very successful in getting their share of the Medicaid dollar. In the future, we must consider the needs of recipients first," he said. Earl proposed that the answer to high health care costs lies in a combination of market incentives and useful government regulation.

Democrat James Wood, on the other hand, said cost and quality of health care was the major health care issue. According to Wood, the economic issue is overshadowing the equally important quality issue. "Access and quality to health care ought not be dependent upon whether or not people can open up their pocketbook. Our goal should be quality health care for every citizen of this state," Wood said.

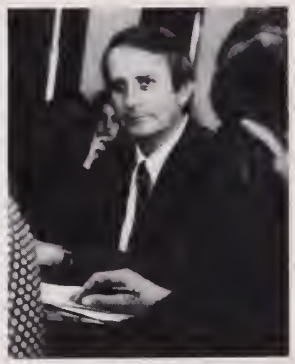
When examining the Medicaid cost problem, former Governor Martin Schreiber said we must examine options to traditional, long-term nursing home care which now consumes 60-70% of the Medicaid budget. He said the future governor should take a look at having the state take over the Medicaid program. Furthermore, Schreiber disagreed with the notion that physicians had substantial responsibility for increasing costs because they are the "gatekeepers" to the health care system. "All society has a role in being a gatekeeper," he said. Schreiber agreed with many of his opponents that copayments and other cost-sharing ideas may be helpful in changing some Medicaid recipients' attitudes that this is a giveaway program.

Both Schreiber and Earl agreed that corrections should be taken out of the Dept of Health and Social Services to allow

Mertin Schreiber

James Wood

Terry Kohler



Anthony Earl

Gereld C Kempthorne, MD (SMS president); William L Treacy, MD (WISPAC chairmen); and Brian Jensen (SMS Physicians Alliance director)

Lowell Jackson (left)
(Staff photos by Neal Neuberger and Diane Upton)

the DHSS secretary to concentrate on health activities. Schreiber also proposed dividing the agency into three independent agencies: 1) health, 2) social services, and 3) corrections.

Much discussion centered on the so-called "free choice" issues of recent legislative sessions such as raising the drinking age, mandating motorcycle helmets, regulating smoking in public places, and mandating provider services in health insurance policies.

Candidates Kohler, Jackson, and Schreiber all unequivocally stated that they are in favor of raising the drinking age to 19. Schreiber also stated he favored the reciprocity proposal; *ie,* you can't drink in Wisconsin unless you can drink in your home state.

Earl and Wood were not so anxious to support raising the legal drinking age. Earl stated that the least effective thing to do was to legislate on this issue. He felt educational programs on alcohol abuse might be useful and said he could be persuaded to raise the drinking age to 19 if someone could show him convincing data that it may curb teenage accidents on the highways. Earl said he might favor reciprocity, although he was unsettled on this.

James Wood favored the reciprocity idea and said he too could be convinced to support a higher drinking age if data supported its usefulness. Meanwhile, he said, to get drinking out of the high schools, "we should say that you can't drink in this state until you've completed a bonafide alcohol education program and have a high school diploma."

Only Terry Kohler said he wouldn't favor regulating smoking in public places, since he felt it wasn't wise public policy. James Wood did not comment on the issue.

In regard to mandating motorcycle helmets, James Wood and Martin Schreiber said they were in favor of reinstituting the law. Kohler said he would leave it in the hands of the Legislature and Earl said he voted for the helmet law when he was in the Legislature, but that he feels less strongly for it now. "It is hard to protect people from themselves," he said.

Jackson said he used to be a strong proponent of helmets, but his experience with motorcyclists when he was secretary of the Dept of Transportation led him to switch to favoring safety programs for motorcycle operators.

Two of the three Democratic candidates were strongly opposed to the concept of mandating chiropractic coverage in insurance policies. Earl and Schreiber both stated that they were strongly opposed to the idea. Schreiber noted that he vetoed such a measure as acting governor and would do so again. Democrat James Wood, however, stated that while he was sympathetic to physicians' arguments that it would require all consumers to pay for a service used by only a small number of people, he said we must find some way to more fairly distinguish which services to leave in and which ones to leave out. "Until this is done," he said, "I think there should be access for the patient who wants it."

Republicans Kohler and Jackson both expressed their dislike for mandates of any kind, especially if there is a private sector alternative. Kohler said that he would listen to what the Legislature wants on this issue, but that he would be opposed to chiropractors being granted admitting privileges in hospitals.

Jackson proposed that a possible solution might be to structure health insurance similar to uninsured motorists insurance: all insurance companies must offer it, but individual policyholders have the option to accept it or not.

When asked about the role state government should have in the licensing and regulation of professions, most of the candidates agreed that professionals should regulate their colleagues.

Earl said he favored maintaining majority professional membership on the examining boards, but felt that some lay membership is useful, since lay people bring a fresh perspective to the board.

Schreiber said he was "bothered" by the concept of bureaucrats regulating professionals.

James Wood would be willing to "experiment with the idea that professions know more about their bad apples than any agency of enforcers in Madison." He wasn't sure that we need the amount of rule-making and regulation that is going on right now.

Republican Lowell Jackson agreed with his Democratic counterparts and stated "peers would be passing judgment on the behavior of their colleagues."

Terry Kohler said he was not familiar enough with this issue, but said he would seek the advice of those covered by Dept of Regulation and Licensing system before making any judgment.

Each candidate was interviewed for one hour and fifteen minutes by 20 members of the WISPAC Board. At the conclusion of the interview process, the Board voted to not issue a preprimary endorsement. ■

Impaired Physician Program progress report

Work continues toward establishing an expanded Statewide Impaired Physician Program. The Managing Committee of the program met August 10 at Society headquarters to assess progress made to date in implementing a timetable established for the program.

Committee members are: SMS President *Gerald C Kempthorne, MD,* (chairman); *Arthur Norris, MD,* medical director, Milwaukee Psychiatric Hospital; *Fred H Koenecke, Jr, MD,* Madison psychiatrist; *Roland Herrington, Jr, MD,* corporate medical director, De Paul Rehabilitation Hospital; *A Bela Maroti,* president, De Paul Rehabilitation Hospital, and *John LaBissoniere,* SMS staff member.

The Committee is currently involved in developing educational programs for physician groups, hospital personnel, pharmacists, nurses, and nursing home administrators regarding impaired physician recognition and prevention. Requests now are being made to Wisconsin hospitals and allied health organizations for opportunities to lecture on this subject.

Moreover, the Committee will be discussing the Impaired Physician Program with the State Bar of Wisconsin in order to obtain the cooperation of attorneys when advising physicians on speaking out on impaired physician problems.

The Statewide Impaired Physician Program is still recruiting physicians to serve as interveners with impaired colleagues throughout the state. Physicians residing in northwestern Wisconsin are especially needed. Physicians interested in volunteering should contact John LaBissoniere at SMS offices in Madison at 608/257-6781 or toll-free 800-362-9080.

An informational brochure detailing the objectives and format of the Impaired Physician Program was approved by the Committee August 10 and will be published by mid-October. ■

SMS President to embark on county society speaking tour

SMS President Gerald C Kempthorne, MD, Spring Green, will be visiting 19 county medical societies over the next several months in an effort to bring the SMS presidency to the membership.

According to the SMS President, the aim of the communications effort is to seek out the opinions and concerns of SMS members throughout the state so that they can be incorporated into Society plans for the future.

Doctor Kempthorne will be visiting the following county medical societies and clinics between September and December 1982: Green, Waukesha, Wood, Price-Taylor, Portage, Marathon, Lincoln, Marshfield Clinic, Kenosha, La Crosse, Pierce-St Croix (Auxiliary Fall Board), Jefferson, Shawano, Door-Kewaunee, Winnebago, Brown, Fond du Lac, Rock, and Waupaca. ■

Membership hits all-time high

For the first time in the history of the State Medical Society, there are over 5,000 members on the SMS roster. The 1981 year-end membership total was 4,891, while as of July 15, 1982, the Society already had 5,049 paid members.

For the second year in a row, the Society has set a new record in adding new members. By mid-July, 171 new members had joined SMS, while last year at this time 166 new members had joined. SMS has now reached its stated goal of 3 percent increase in new members for 1982, a rate of growth consistent with the growth in the total number of physicians in Wisconsin.

Membership resignations are down for the year. Thus far, 24 physicians have resigned, eight of whom have already been reelected or reinstated. In 1981, 167 members were dropped from membership due to nonpayment; in 1982 this number dropped to 152, and 66 of these have already been reinstated. ■

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The Charitable, Educational and Scientific Foundation of the State Medical Society is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for July 1982.

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CERTIFICATES OF APPRECIATION. Shown at left (L to R) is Fort Crawford Medical Museum Managing Committee Chairman Richard W Edwards, MD, Richland Center, presenting certificates of appreciation July 17 to Thomas F Farrell, MD; JA Druyor, and MJ Dyrud, all of Prairie du Chien. The three men are founding members of the William Beaumont Memorial Foundation established in 1943 to restore the original Fort Crawford into the present day Medical Museum at Prairie du Chien. (Photo by Ben Bartel)■

Membership classifications for new and future physicians

The State Medical Society of Wisconsin is asking new and future physicians to become a part of organized medicine early in their careers, including students entering medical school. Changes in Society policy have made this possible by creating attractive dues-reduced or waived membership classifications.

"THE MADONNA." Thomas A Leonard Jr, MD, Middleton, is shown here holding "The Madonna," a sculpture he designed and presented to the Charitable, Educational and Scientific Foundation during its Board of Trustees meeting at the Fort Crawford Medical Museum at Prairie du Chien July 17. The sculpture is a tribute to Wisconsin physicians for contributions they have made to decrease infant and maternal mortality. (Photo by Ben Bartel)■

The Candidate member is a new category for medical students and Postgraduate-one. Dues are waived for Freshmen and are only $10.00 for others in this classification.

Resident physicians pay only 10 percent of regular dues.

The physician who is elected to membership in this Society within six months of completing residency, fellowship, or fulfillment of government obligation enjoys a dues reduction of 50 percent for the first year and 25 percent the second year.

The AMA has very low dues structure for the Student Member and Resident Member as well. In addition, to attract new members the AMA has a reduction of dues for the new practitioner of 50 percent for the first year and 25 percent the second year.

Physicians are urged to seriously consider joining organized medicine as early as possible to take advantage of these special membership rates.

To begin the membership process, if your practice is or will be located in Wisconsin, complete the form below. If you have any questions, you may contact your local county society or call the toll-free number of the State Medical Society: 1-800-362-9080 (Madison area number: 257-6781).■

TO: State Medical Society of Wisconsin, Membership Dept, PO Box 1109, Madison, Wisconsin 53701

YES, I am interested in organized medicine. Please send me more information about the benefits of membership.

NAME _____

MAILING ADDRESS _____

_____

_____

COUNTY (principal practice located) _____

_____

Nominations sought for SMS Offices

Are you interested in seeking a State Medical Society office, or do you know someone who is? The Nominating Committee of the SMS House of Delegates is meeting in conjunction with the SMS Leadership Conference November 12-13 at the Brookfield Marriott. The Committee will be seeking nominations for the following positions for which a slate of candidates will be presented to the House of Delegates for the 1983 Annual Meeting, March 24-25: President-elect for 1983-84; Treasurer for 1983-84 to succeed John J Foley, MD, Menomonee Falls; Speaker of the House of Delegates for 1983-85 to succeed Duane W Taebel, MD, La Crosse; AMA delegates for calendar years 1984 and 1985 to succeed Henry F Twelmeyer, MD, Wauwatosa and Richard W Edwards, MD, Richland Center; AMA alternate delegates for calendar years 1984 and 1985 to succeed JD Kabler, MD, Madison and Kenneth M Viste Jr, MD, Oshkosh. Nominations, curriculum vitae, and a statement of willingness to serve if elected should be mailed to SMS offices prior to the November meeting date.

All incumbents are eligible for reelection. ■

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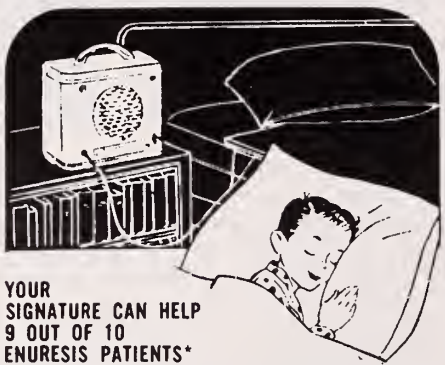

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Spouse physicians take note

Responding to a request of the House of Delegates, the Board of Directors has approved a dues reduction for one physician whose spouse also is a physician as an incentive for both to maintain Society membership. This is to become effective for dues payable January 1 following the request.

One of the members of such two-physician families would be entitled to a dues break of $50. The other would pay full dues. The members themselves would identify which one receives the discounted rate.

The Society requests that such two-physician families use the home address for mailings so as to assure equal access to the Society's communications. The reduction of dues is supported by eliminating duplication of Society mailings, including the *Wisconsin Medical Journal* and *Medigram.*

Spouse physicians are urged to identify themselves as two-physician families and request the dues reduction of $50 for one member of the family. ■

Reduced Practice or Retired Membership Classifications

The State Medical Society reminds physicians who have reduced their practice to 1000 hours or less during the calendar year, but do not qualify for Retired Membership, that they may apply for a "Part-time Practice" classification which waives 50 percent of the regular membership dues.

In addition, the Society reminds physicians who have reached age 70, but are still practicing, that they now qualify for "Over Age 70" classification and will receive a reduction of regular SMS dues by 50 percent.

These special membership classifications must be applied for through the physician's county or state society. The changes will become effective January 1 following approval or the year after the physician reaches the age of 70 and cannot be made retroactive.

Other classifications which may be requested for which dues exemptions may apply are:

Associate: illness or financial hardship
Retired: works less than 240 hours per year
Military Service: temporary service in the Armed Forces or National Health Service

Some county societies have reduced or waived dues for the same classifications as the State Medical Society, also the American Medical Association.

The State Medical Society urges all physicians who are retired or will be retiring to advise their county or state society of their present or future status so that a change in classifications can be arranged. ■

County Societies

*Physician members of State Medical Society of Wisconsin

CLARK: At the August meeting of the Clark County Medical Society, the guest speaker was Norman A Desbiens, MD* of Ladysmith. Doctor Desbiens is a member of the Rusk County Medical Society and spoke on "Hemodynamic Monitoring in the Community Hospital."

MILWAUKEE AUXILIARY

Fifty years of service

The Auxiliary to the Medical Society of Milwaukee County will celebrate its 50th year with a benefit dinner-dance on Saturday, October 30, with contributions going to the American Medical Association Education Research Foundation (AMA-ERF). It will be a time for members, spouses, and friends to meet and reminisce about the "good old times."

Milwaukee Auxilians have enjoyed a notable series of accomplishments over this span of years. Even before the Milwaukee County Medical Auxiliary was founded, service-minded women were active in the establishment of the State Medical Auxiliary in 1929. The State Society's first president was Mrs T L Harrington of Milwaukee; she was to be followed by many Milwaukee Auxilians in that leadership role.

Mrs James C Sargent was elected the first president of the Milwaukee County Auxiliary. The purpose of the Auxiliary was stated "as being social, educational, and philanthropic—the educational side should be stressed." That year this fledgling group hosted the State Medical Auxiliary Convention.

Soon, following this success, the second president, Mrs Rock Sleyster, confidentially accepted the awesome task of welcoming the American Medical Association Convention to Milwaukee and becoming the National Convention's General Chairman. AMA Auxiliary president, Mrs James F Percy, voted it as "the best convention ever held."

Since then the Auxiliary has grown and expanded its interest in many health-related fields. The theme of its Anniversary Year is appropriately "50 Years of Service."

Mrs Robert Kastelic, president, will pursue the founders' initiatives. Of great concern is the plight of medical education and research. So, as has been traditional over the years, the Auxiliary will celebrate its Golden Anniversary by raising funds for AMA-ERF, presenting a golden opportunity for supporting medical education, providing financial assistance to medical students, grants to our medical schools, fostering scientific and medical research, and funds for health projects.

The Milwaukee Auxilians extend a cordial invitation to all State Auxilians and physicians to join them in celebration, supporting the high standards of medical education in America.

For more information and/or reservations: Mrs Philip Mally—414/453-6963 or Mrs Lloyd Jenk—414/476-7950. ■

POLK: At a recent meeting of the Polk County Medical Society, Dr Ron Pizinger of St Paul, Minnesota was the guest speaker. His paper was entitled "Gastric Emptying and the Use of Reglan." In the business session of the meeting, it was approved that the Polk County Emergency Medical crews be allowed to use mask trousers on the scene after they obtained an order via radio with the physician. There were 12 members present at the meeting. ■

Specialty Societies

*Physician members of State Medical Society of Wisconsin

Milwaukee Ophthalmological Society will hold its first meeting of the 1982-83 season on Wednesday, Oct 20, 1982 at the University Club, Milwaukee, with Gerald W Wadina, MD,* president, presiding. The meeting is being held somewhat earlier than usual because of the international meeting in San Francisco, in conjunction with the Academy meeting. The scientific program will be presented by Marilyn C Kay, MD of the Neuro-Ophthalmology Service, The Medical College of Wisconsin. Doctor Kay will speak on "Neuro-Ophthalmology Findings and Closed Head Injury." Further information regarding reservations or society membership may be obtained by contacting Robert A Hyndiuk, MD,* treasurer, Department of Ophthalmology, The Medical College of Wisconsin, 8700 West Wisconsin Ave, Milwaukee, Wisconsin 53226; ph 414/476-9722. ■

Blue Book-Update

In the listing on page 108 of the July "Blue Book" under the Commission on Continuing Medical Education, the chairman is *James T Houlihan, MD,* Woodruff, and the vice chairman is *C William Freeby, MD* of Appleton.

It was erroneously reported in the August issue, pages 47 and 54, that *Conrad L Andringa, MD,* Madison, was appointed to the Committee on Aging and Extended Care Facilities, when in fact *Sailendra Basu, MD,* Wausau, was appointed to that committee. Other committee appointments omitted from the August issue are the following: Committee on Environmental and Occupational Health—*Susan M Wester, MD,* La Crosse; medical Advisory Committee to WIAA (a subcommittee of SMS Committee on School Health)—*John M Kirsch, MD,* Stevens Point, and *Conrad L Andringa, MD,* Madison. *Robert E Phillips, MD,* Marshfield, who was reported in the August issue as being appointed to the Committee on Aging and Extended Care Facilities, replaces *Phillip M Green, MD,* Marshfield, on that committee. These committee listings appear in the "Blue Book" on pages 111-112. ■

Obituaries

E Paul Tischer, MD, 69, Evansville, Ind, died Apr 21, 1982 in Evansville. Born Aug 3, 1912 in Mount Vernon, New York, Doctor Tischer graduated from the Indiana University School of Medicine in Bloomington and served his internship and residency at Indianapolis General Hospital. He had served in the United States Air Force from 1942-1946. Doctor Tischer had practiced in Indianapolis until he moved to Richland Center in 1969. He was a member of the Richland County Medical Society, State Medical Society of Wisconsin, and the American Medical Association.

Linwood C Gardner, MD, 85, Fond du Lac, died June 1, 1982 in Fond du Lac. Born Jan 16, 1897 in South Wayne, Doctor Gardner graduated from the University of Iowa Medical School in 1921 and served his internship at Harper Hospital in Detroit. He practiced medicine in Hawarden, Iowa, for two years before returning to the University of Iowa to complete his residency in otolaryngology. He practiced medicine in Fond du Lac for 42 years before retiring in 1969. He was a former chief-of-staff of St Agnes Hospital and a past president of the Central Wisconsin-Upper Michigan Nose and Throat Society. He was a member and past president of the Fond du Lac County Medical Society, and a member of the State Medical Society of Wisconsin and the American Medical Association. Surviving is his widow, Gladys.

Francis L Hummer, MD, 77, Sun City, Ariz, died June 6, 1982 in Sun City. Born July 7, 1904 in Washington, DC, Doctor Hummer graduated from George Washington University Medical School and served his internship at Providence Hospital, Washington, DC. He served in the United States Naval Medical Corps from 1942-1946. He practiced medicine in Madison from 1947-1970 when he moved to Sun City, Ariz. He was a member of the Dane County Medical Society, State Medical Society of Wisconsin, and the American Medical Association. Surviving are his widow and two children.

Earl C Quackenbush, MD, 78, Hartford, died June 14, 1982 in Hartford. Born June 19, 1903 in Green Bay, Doctor Quackenbush graduated from Northwestern University Medical School in 1929 and served his internship at Milwaukee County Hospital. His residency was completed at New York Lying-In Hospital and Johnston Emergency Hospital. Doctor Quackenbush had practiced in Iron Ridge from 1933 until 1944 when he moved to Hartford. He retired in 1970. He served on the Committee on Public Policy of the State Medical Society of Wisconsin and also was a delegate for several years. Doctor Quackenbush was inducted into the "50 Year Club" of the Society in 1979. He was a member of the Washington County Medical Society and the American Medical Association. Surviving are his widow, Jo; and one son, James Earl of Middleton.

Isadore H Schultz, MD, 83, Mazomanie, died June 19, 1982 in Madison. Born Aug 3, 1898 in Russia, Doctor Schultz graduated from the University of Wisconsin Medical School, Madison, and served his internship at St Marys Hospital, Madison. Doctor Schultz had his medical practice in Mazomanie from 1931-1967 until his retirement. At age 69, Doctor Schultz served a two-month volunteer duty in Vietnam. He was a member of the Dane County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association. Surviving is a sister, Dr Zena Schliomozvich of Minsk, Russia.

Mark H Gia Russo, MD, 36, Menomonee Falls, died June 23, 1982 in Menomonee Falls. Born Sept 8, 1945 in Milwaukee, Doctor Gia Russo graduated from the University of Wisconsin Medical School, Madison, and served his internship at Akron General Medical Center, Ohio, and a residency at the Albany Medical Center in New York. Doctor Gia Russo was a neurologist at the Medical Associates Health Center in Menomonee Falls. He was a member of the Waukesha County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association. Surviving are his parents, Reverend and Mrs Gia Russo of New Berlin.

Stephen F DeFazio, MD, 86, Kenosha, died June 25, 1982 in Kenosha. Born Sept 15, 1895 in Catanzaro, Italy, Doctor DeFazio graduated from Marquette University School of Medicine in 1932 and served his internship at St Joseph Hospital in Milwaukee. His residency was completed at St Joseph Hospital in Lexington, Ky. Doctor DeFazio was a member of the medical staff of Kenosha Memorial Hospital and had served as president. He also had served on the board of directors for the Kenosha Blood Bank. He was a member of the Kenosha County Medical Society, a "50 Year Club" member of the State Medical Society of Wisconsin and the American Medical Association. Surviving are his widow and three sons.

Benjamin H Brunkow, MD, 78, Monroe, died June 30, 1982 in Monroe. Born Jan 24, 1904 in Monroe, Doctor Brunkow graduated from the University of Wisconsin Medical School, Madison, and served his internship at Ankor Hospital in St Paul, Minn. After a medical practice of several years in Montana, he completed a residency, in urology, at the University of Pennsylvania in Philadelphia. He served in the United States Army Medical Corps from 1942-46 during World War II. Doctor Brunkow became associated with the Monroe Clinic in 1946 and retired in 1974. He was a member and past president of the Wisconsin Urology Society; a member of the American and International College of Surgeons, a member of the Green County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association. Surviving is his widow, Rosena.

Frank B Sazama, MD, 74, Chippewa Falls, died July 3, 1982 in Chippewa Falls. Born Aug 12, 1907 in Colby, Doctor Sazama graduated from Rush Medical College, Chicago, in 1934 and served his internship at St Francis Hospital in Evanston, Ill. Doctor Sazama began his medical practice in Chippewa Falls in 1935 and practiced medicine until his retirement to Scottsdale, Ariz, in 1970. While in Arizona, he was a member of the medical staff of the Arizona State Hospital. Doctor Sazama was a member of the American Society of Abdominal Surgeons and a Fellow of the International College of Surgeons. He also was a member of the Chippewa County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association. Surviving are three children; a son, Gerald, Chippewa Falls; two daughters, Mrs Neil (Ann) Goodall, Chippewa Falls, and Mrs John (Alice) McKenzie of Concord, Calif; and a brother, Dr John J Sazama of Chippewa Falls.

George D Skow, MD, 78, Racine, died July 6, 1982 in Racine. Born Mar 3, 1904 in Racine, Doctor Skow graduated from Marquette University School of Medicine in 1937 and served his internship at California Hospital in Los Angeles. Doctor Skow served as a flight surgeon with the Army Air Corps and during the Korean War served with the United States Navy Medical Corps. He had practiced in the Racine area from 1950 until his retirement in 1977. He was a member of the Racine County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association. Surviving are one daughter, Mrs Wendy Brown, Gaithersburg, Md; and two sons, George D, II, and Jon of Racine.

John C Yockey, Sr, MD, 84, Fond du Lac physician for over 50 years, died July 10, 1982 in Mount Calvary. Born Sept 25, 1897 in Champaign, Ill, Doctor Yockey graduated from the University of Illinois College of Medicine in 1924 and served his internship at St Luke's Hospital in Chicago. He had been associated with the Fond du Lac Clinic since 1926. He was a member of the Fond du Lac County Medical Society, State Medical Society of Wisconsin, and the American Medical Association. Surviving are his widow; one daughter, Barbara Ruth, Chicago; and four sons, Dr John C Jr, Richard B, Thomas J, all of Fond du Lac and Robert F of Plymouth.

John J Tordoff, MD, 65, former chief of staff at Mercy Hospital, Janesville, died July 12, 1982 in Janesville. Born Feb 20, 1917 in Madison, Doctor Tordoff graduated from Marquette University School of Medicine and served his internship at St Mary's Hospital in Milwaukee. His residency was completed at the Veterans Administration Hospital in Wood. Doctor Tordoff served in the United States Navy from 1941-1947. He had practiced medicine in Janesville from 1953 until his retirement in 1981. He was a member of the Wisconsin Surgical Society, American College of Surgeons, Rock County Medical Society, State Medical Society of Wisconsin, and the American Medical Association. Surviving are his widow; four sons, John, Ketchikan, Alaska; James, Port Townsend, Wash; David and Robert, both at home; and two daughters, Jane E Van Skike, Janesville, and Mary of Rochester, New York.

Edward L Martineau, MD, 83, Shorewood, died July 16, 1982 in Milwaukee. Born Apr 27, 1899 in Oconto, Doctor Martineau graduated from Marquette Medical School in 1928 and served his internship at Milwaukee County General Hospital. Doctor Martineau was a "50 Year Club" member of the State Medical Society of Wisconsin, a member of The Medical Society of Milwaukee County, and American Medical Association. Surviving are two sons, Antoine and Edward Jr; and three daughters, Marianne Coyle; Betsy Sullivan; and Jeanne Keck.

Albert G Schutte, MD, 87, formerly of Mukwonago and Milwaukee, died July 17, 1982 in Arvada, Colo. Doctor Schutte graduated from Marquette University School of Medicine in 1928 and served his internship at Mt Sinai Hospital, Milwaukee. He was an Emeritus Professor of Surgery at Marquette University School of Medicine and had served on the consulting staffs of West Allis Memorial, Milwaukee County General, Columbia, and Mt Sinai hospitals. He was a member of the American Proctologic Society and the Tri State Proctologic Society. He also was a member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association. Surviving are his widow, Bernice; a son, Thomas; and two daughters, Mary Donovan and Sarajane Peters.

Masaud Ahmed Farooq, MD, 49, Waupun, died July 20, 1982 in Madison. Born Mar 11, 1933 in India, Doctor Farooq graduated from Mahatma Ghandi Memorial Medical College, India, and served his internship and residency at St Luke Hospital, St Paul, Minn. He also had four years of residency at Glenwood Hills Hospital in Minneapolis. Doctor Farooq had practiced in Cook, Minn, before opening his medical practice in Waupun. He was on the medical staffs of Waupun Memorial and Ripon Memorial hospitals and Hillside Hospital in Beaver Dam. He was a member of the American Society of Abdominal Surgeons. Surviving are his widow, Suzanne; one daughter, Yasmin, and two sons, Michael and James, all at home.

Robert O Johnson, MD, 61, Madison, died July 30, 1982 in Madison. Born Feb 27, 1921 in Eau Claire, Doctor Johnson graduated from the University of Wisconsin Medical School, Madison, and served his internship at Philadelphia General Hospital in Pennsylvania. He practiced in Bottineau, North Dakota until 1957 and returned to the University of Wisconsin where he completed a residency in surgery. Doctor Johnson was a professor of surgery and clinical oncology and was a leader in the field of cancer research and treatment at the University of Wisconsin. He had served as Director of Clinical Oncology; as a consultant at the Veterans Administration Hospital, Madison; was on the hospital board at the University of Wisconsin Medical Center; and had served as chief-of-staff at University Hospital and Clinics. He also was associate director of the Wisconsin Clinical Cancer Center in Madison. Since 1978 he had served as the Cancer Control Program Director. Surviving are four sons, Robert A, Madison; Richard E, Madison; Michael D, Chicago; and Mark S, Madison; and a daughter, Anne E of Madison. ■

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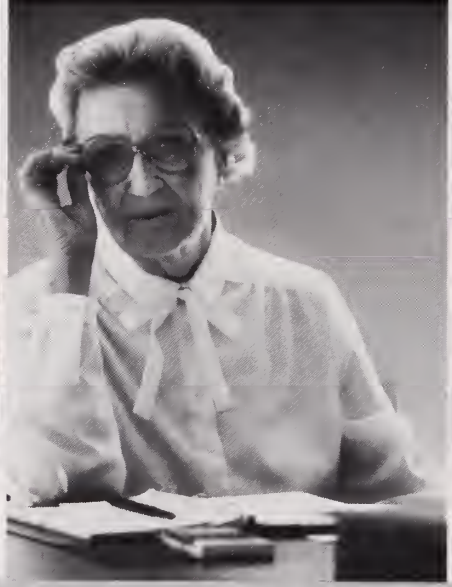

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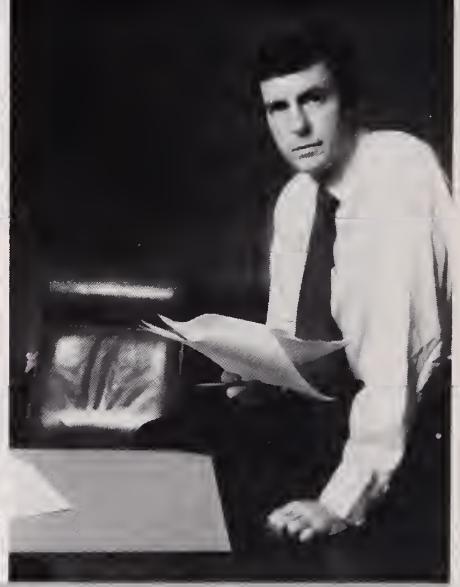

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Physician Briefs

*Physician members of State Medical Society of Wisconsin

Michael G McHenry, MD,* Green Bay, has joined the medical practice of MDs Chester W Crawford* and Wesley E McNeal* of Family Practice Associates of Green Bay. Doctor McHenry graduated from the University of Wisconsin Medical School, Madison, and completed his residency at St Mary's Hospital in Madison.

George S Irwin, MD, Wisconsin Rapids, recently joined the medical practice of John W McDonough, MD.* Doctor Irwin graduated from the University of Illinois College of Medicine and most recently was an instructor in orthopedic surgery at the University of Illinois.

John T Harrington Jr, MD,* Madison, recently was the guest speaker at the Watertown Rotary Club. Doctor Harrington, who specializes in the field of rheumatology, spoke on "Arthritis: A Misunderstood Problem." A member of the medical staff of the Dean Clinic, Doctor Harrington has served as an assistant professor at the University of Texas Health Center, San Antonio, and has been an assistant clinical professor at the University of Wisconsin Medical School, Madison, since 1977.

Dean Mancheski, MD, Sheboygan, recently began his medical practice with the Marsho Medical Center. He graduated from the University of Wisconsin Medical School, Madison, and completed his family practice residency program at the Wausau Hospital Center.

Michael E Ryan, MD, Marshfield, has joined the medical staff of the Marshfield Clinic in the Department of Internal Medicine. A graduate of the University of Minnesota Medical School, Doctor Ryan served an internship and residency at the University of Minnesota Hospitals, and then completed a fellowship in gastroenterology at the University of Wisconsin in Madison.

J G Kotynek, MD, Superior, recently joined the medical staff of The Superior Clinic, Ltd. Doctor Kotynek graduated from the University of Illinois School of Medicine and completed his surgical residency at University Hospital and Clinics in Madison. He also is affiliated with the medical staff of Superior Memorial Hospital.

Richard M. Reich, MD,* recently became associated with the medical staff of the Jackson Clinic, Madison, in the Department of Internal Medicine. Doctor Reich graduated from Cornell University Medical College in New York, and completed his internship and residency in infectious diseases at the University Hospital and Clinics, Madison. He also completed a fellowship in geriatrics at the Wm S Middleton Veterans Administration Hospital in Madison.

Steven R Quackenbush, MD,* has joined the medical staff of the Howard Young Medical Center in Woodruff. Doctor Quackenbush is head of the laboratory and pathology departments of the hospitals. He graduated from Kansas University Medical School, and completed his residency training at St Joseph Hospital in Milwaukee.

Floyd Dauenhauer, Jr, MD, Wisconsin Rapids, has joined the medical staff of the Riverwood Clinic, SC. He also is a member of the medical staff of the Riverview Hospital. Doctor Dauenhauer graduated from the University of Texas Medical School, Galveston, and completed his residency in obstetrics and gynecology at Scott & White Memorial Hospital in Temple, Tex. Doctor Dauenhauer is a junior fellow in the American College of Obstetricians and Gynecologists.

James S McVeety, MD, Marshfield, recently became associated with the medical staff of the Marshfield Clinic in the Department of Neurology. He graduated from the University of Bologna in Italy, and completed an internship at Nassau Hospital in Mineola, New York. His residency was taken at the University of Miami.

Susan Kinast-Porter, MD, Monroe, has joined the medical staff of The Monroe Clinic. Doctor Kinast-Porter graduated from the University of Illinois Medical School, and completed her residency training program at St Mary's Hospital Medical Center in Madison.

Earl G Gloeckner, MD,* Lake Geneva, recently joined the medical practice of Nicholas W Veith, MD.* Doctor Gloeckner graduated from the University of Iowa Medical School and served an internship at the Marshfield Clinic. He completed his residency and fellowship training at University Hospital and Clinics in Madison, where he also served as a clinical instructor in the University of Wisconsin Medical School, Department of Ophthalmology.

Thomas Ries, MD, Sheboygan, has joined the medical staff of the Sheboygan Clinic. A specialist in obstetrics and gynecology, Doctor Ries graduated from the University of Wisconsin Medical School in Madison. He completed his residency training at St Joseph Hospital in Milwaukee.

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John R Krueger, MD, Cedarburg, recently became associated with Thomas J Shewczyk, MD* in Cedarburg. Doctor Krueger graduated from the University of Wisconsin Medical School, Madison, and completed his residency program in family practice at St Mary's Hospital in Milwaukee. He is affiliated with St Alphonsus Hospital, Port Washington, and St Mary's Hospital, Milwaukee.

Kay E Jewell, MD,* Milwaukee, recently became medical director of the Wisconsin Veterans Home, King, replacing Oscar P Ansaldo, MD* who has been acting director. Doctor Ansaldo will remain on the medical staff. Doctor Jewell graduated from the University of Wisconsin Medical School, Madison, in 1979, and served her residency at Mount Sinai Medical Center in Milwaukee.

Kathleen McGinnis, MD, Stevens Point, has joined the medical staff of the Rice Clinic. Doctor McGinnis is a graduate of the Stritch School of Medicine at Loyola University in Chicago, and served her internship at the Marshfield Clinic and St Joseph's Hospital in Marshfield. She has been a general medical officer for the US Public Health Service in Bethel, Alaska, and was a staff physician at Oregon State University Health Center. Prior to joining the Rice Clinic, Doctor McGinnis was a public health physician for the city of Milwaukee, and also had served as a staff physician at Bradley Medical Center in Milwaukee.

Steven J Savonen, MD, La Crosse, recently joined the medical staff of Skemp-Grandview-La Crosse Clinic. Doctor Savonen graduated from the University of South Dakota School of Medicine and served a residency in orthopedic surgery at Tufts University of Medicine. He most recently has been chief resident in orthopedic surgery at Boston Veterans Administration Medical Center.

Alfred E Lounsbury Jr, MD, Superior, recently joined the medical staff of the Superior Clinic. Doctor Lounsbury graduated from the University of Minnesota Medical School, and served his residency in internal medicine at the University of Minnesota Hospitals.

Frederick C Skemp Sr, MD,* La Crosse, recently retired from medical practice. A 1933 graduate from the Marquette University Medical School, Doctor Skemp had practiced in Fountain City until 1954 when he joined the Skemp Clinic in La Crosse. Although he is no longer seeing patients in his office, Doctor Skemp will stay active on a part-time basis assisting in surgery.

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Krishna Bhatt, MD, Manitowoc, has joined the medical staff of Holy Family Hospital. A native of Nairobi, Kenya, Doctor Bhatt completed a residency in neurology at the University of Kentucky Medical Center and also completed a residency in psychiatry at Michigan State University in Traverse City, Mich.

Frank J Gallagher, MD,* La Crosse, who has been in medical practice in the La Crosse area since 1937, has retired. Although no longer seeing patients in his offices, Doctor Gallagher is a consultant at the Family Practice Residency Program.

Edwin L Overholt, MD,* director of medical education at the Gundersen Medical Foundation Ltd, La Crosse, recently was elected to a four-year term as governor of the American College of Physicians.

Mark Mirick, MD, Wausau, has joined Wisconsin Emergency Medical Services Associates which provides emergency department services at Wausau Hospital Center. A graduate from the University of Iowa Medical School, Doctor Mirick served his residency at the Hennepin County Medical Center in Minneapolis. Prior to moving to Wausau, he had associated with the Department of Trauma and Emergency Medicine at North Memorial Medical Center in Minneapolis.

W Dudley Johnson, MD,* Milwaukee, associate clinical professor of surgery, The Medical College of Wisconsin, Milwaukee, will be one of the guest faculty members on the 3-day program on the latest in diagnostic and therapeutic techniques in clinical cardiology. The program, sponsored by the American College of Cardiology and the Cardiovascular Division of the Medical University of South Carolina's College of Medicine, will be held in Charleston, SC, on October 14-16. The seminar entitled "Clinical Cardiology—Update on Diagnostic and Therapeutic Techniques," will include lectures, question and answer panels, clinical workshops and demonstration of echocardiographic and radionuclide equipment.

Donald J Harvey, MD, * Sheboygan Falls, and **Alan C Reynolds, MD,** Milwaukee, recently were certified as diplomates of the American Board of Anesthesiology.

Mark Wisnefske, MD, Marshfield, recently joined the medical staff of the Marshfield Clinic. Doctor Wisnefske graduated from the Medical College of Wisconsin, Milwaukee, and served his internship and residency in orthopedic surgery at the University of Oklahoma Health Sciences Center in Oklahoma City.

Mary H Leikness, MD, Berlin, recently became associated with the medical staff of Berlin Memorial Hospital. Doctor Leikness graduated from the University of Wisconsin Medical School, Madison, and served her residency in urology at University Hospital and Clinics in Madison.

Timothy J Maatman, MD, Manitowoc, has joined the Manitowoc Clinic in the Department of Internal Medicine. Doctor Maatman graduated from the University of Michigan Medical School, and completed his internship at the University of Kentucky Hospitals in Lexington. His residency was completed at Henry Ford Hospital in Detroit, where he was chief medical resident for two years.

Charles Luetke, MD, recently was named an associate member of the Luther Hospital medical staff in Eau Claire. Doctor Luetke, whose specialty is internal medicine, is working in the Department of Emergency Medicine. He is a graduate from the University of Wisconsin Medical School, Madison, and completed his residency at the Berkshire Medical Center in Pittsfield, Mass.

Robert J Aylesworth, MD, Rhinelander, recently joined the medical staff of the W S Bump Medical Group, SC. He graduated from the University of Wisconsin Medical School, Madison, and completed his residency at University Hospital and Clinics, Madison, and also at the University of Minnesota in Minneapolis.

Thomas Gerber, MD, Rice Lake, recently opened his medical practice in otolaryngology. Doctor Gerber graduated from The Medical College of Wisconsin, Milwaukee, and completed his residency at the Medical College of Wisconsin Affiliated Hospitals. Doctor Gerber is on the medical staff of the Lakeview Medical Center.

Naglaa M Shebab, MD, Ladysmith, recently joined the medical staff of the Marshfield Clinic-Ladysmith Center. A graduate from Kasr El Aini Medical School of the University of Cairo, Egypt, she completed her residencies in obstetrics, gynecology and general surgery at Ain-Shams University also in Cairo. She was in private practice in Egypt for six years and came to the United States and completed further training at King's County Hospital/Down State Medical Center, Brooklyn, and Jersey City Medical Center.

David M Ebben, MD, Fond du Lac, recently joined the medical staff of Associated Physicians in Fond du Lac. He graduated from the University of Wisconsin Medical School, Madison, and completed his residency at the Cedar Rapids Family Practice Residency Program in Iowa. Doctor Ebben is one of the group of physicians serving the Campbellsport area. He is a member of the medical staff of St Agnes Hospital in Fond du Lac.

Saleem Bakhtiar, MD, Hartford, recently joined the medical staff of the Hartford Clinic. Doctor Bakhtiar graduated from Dow Medical College, Katachi, Pakistan in 1975 and worked as a house surgeon at the Royal College of Surgeons in London, England, before coming to the United States in 1977. He served his residency at Mount Sinai Medical Center and at the Medical College of Wisconsin in Milwaukee. ■

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AMA Physician's Recognition Award Recipients

LISTED BELOW are those physicians in Wisconsin who have earned the AMA Physician's Recognition Award in recent months. The award was established in 1969 "to recognize, encourage and support physicians who participate regularly in continuing medical education and to emphasize the importance of developing more meaningful continuing medical education opportunities for physicians." A minimum of 150 credit hours of CME must be earned over a three-year period to qualify for the award. The hours may include such activities as conferences, residencies, teaching, writing, private reading, listening to cassettes, home study courses, consultation, and peer review; at least 60 of the hours, however, must be from formal CME programs sponsored or cosponsored by organizations accredited for these activities. The State Medical Society of Wisconsin congratulates the following physicians who have distinguished themselves and their profession by their commitment to continuing education:

MAY 1982

*Ancheta, Valentino S, Algoma
Barry, Daniel J, Madison
Bearelly, Manoher R, Milwaukee
*Blau, Edward B, Marshfield
*Boren, Clark H, Marinette
*Brauer, Warren A, Sheboygan
*Browell, John N, Marshfield
*Brown, Jack D, Sparta
*Bruhn, Irwin J, Walworth
*Buhl, John L, Waukesha
Cabatingan, Jaime D, Cedarburg
*Chambers, Richard K, Hartland
*Clothier, W J Kilburn, Waukesha
*Cody, Edward F, Beaver Dam
Dale, Henry L, Milwaukee
Damiani, Kathleen K, Racine
*Dugan, Thomas E, Waukesha
*Eckstrom, Philip T, Brookfield
*Feigal, Michael D, Menomonie
Feinsilver, Donald L, Milwaukee
*Ferrer, Modesto M, Tomahawk
*Finucane, Patrick J, Eau Claire
*Fischer, Herbert K J, Marshfield
*Galgano, Rocco S, Delavan
*Garber, Bradley G, Osseo
*Gardner, James D, Waukesha
Gingrass, Ruedi P, Milwaukee
*Goren, Carolyn, La Crosse
*Gramowski, Walter A, Stevens Point
*Gray, Roger S, Evansville
*Gremmels, Frederick C, Watertown
Gross, Richard A, Milwaukee
*Grundahl, Alvin T, West Bend
*Hanke, Richard W, Milwaukee
*Hankey, Terry L, Waupaca
*Hansel, Robert G, Baraboo
*Hartlaub, Eugene S, Janesville
Hawes, Jane A, Milwaukee
*Heighway, Thomas F, Middleton
*Heinen, Robert D, Stockbridge
*Herszenson, Sidney, Milwaukee
*Holtey, Warren J, Marshfield
*Honish, John S, Oconto
Icken, James N, Columbus
*Johnson, Robert B, River Falls
*Keiser, Orris S, De Pere
*Kempthorne, Gerald C, Spring Green
*Kohler, Sidney H, Milwaukee
*Koob, Lynn D, Rice Lake
*Kordiyak, George, Wausau
*Kulkoski, Bernard, Green Bay
*Kuter, David P, Baraboo

Members of the State Medical Society of Wisconsin

*La Joie, William J, Waukesha
*Leasum, Robert N, Osseo
*Matzke, Rudolf W, Spooner
*Merkow, William, Waukesha
Mohammad-Zadeh, Ali A, Green Bay
Navarra, Miguel, Milwaukee
*Nemec, George, Woodruff
*Nice, Marvin L, Kenosha
*Nymo, Mark T, Rice Lake
*Pawlak, James R, Sheboygan
*Peterson, Thomas H, Wausau
*Phelps, Lynn A, Madison
*Plautz, Arthur C, Janesville
*Pope, George M, River Falls
*Reinardy, Michael J, Antigo
*Reinhard, Harold J, Green Bay
*Riegel, Fred B, St Croix Falls
Robken, Jon A, Menomonee Falls
*Rykwalder, Paul J, Menomonee Falls
*Satory, John J, La Crosse
*Schroeder, Norman J, Beaver Dam
*Schulz, Emil, Eau Claire
*Schwarz, Robert L, Menomonee Falls
*Sciarra, Paschal A, Sheboygan
*Sellers, Robert L, Superior
*Seno, Louis S, Milwaukee
*Sherkow, Larry H, Milwaukee
*Shropshire, Richard W, Madison
*Skupniewicz, Raymond E, Racine
*Smirl, Warren G, Waukesha
*Springer, Joseph P, Durand
*Stack, Edward G J, Superior
*Stemper, John A, Milwaukee
*Stewart, Richard D, Racine
Strube, Roger H, Milwaukee
*Thompson, John E, Nekoosa
Tomlinson, Carol, Janesville
Towne, Jonathon B, Milwaukee
*Van Pernis, Paul, Ashland
*Vernier, Edward M, Ashland
*Walsh, Patrick R, Milwaukee
*Wernick, Shelley, Milwaukee
*Whaley, Ralph C, Barron
*Wright, William E, Mondovi
*Yllas, Santiago L, Racine

JUNE 1982

Antisdel, Thomas J, Milwaukee
*Beier, James J, Mosinee
Bockelman, Henry W, Middleton
*Borman, Milton C, Milwaukee
*Bojard, Robert S, Milwaukee
*Burko, Henry, Milwaukee
*Chen, Melvin C, Marshfield
*Cohen, David A, Edgerton
Cohen, Erik N, Bayside
Cunningham, James A, Wauwatosa
*Davis, John B, Verona
Dibbell, David G, Madison
Eidsmoe, Noland A, Rice Lake
*El-Wakil, Mamdouh E, Superior
*Erickson, Scott S, Marshfield
Flake, Charles R, Milwaukee
*Fletcher, Fred W, Eagle River
Fox, Richard E, La Crosse
*Gilbert, Francis, Kewaunee
*Glicklich, Lucille B, Milwaukee
Hansen, Mark A, Jefferson
Houser, John W, Racine
*Hutter, Adolph M, Madison
*Keller, Thomas A, Manitowoc
Kinast-Porter, Susan, Monroe
*Koll-Frazier, Jane H, Fond du Lac
*Kunkel, James A, Marshfield
*Lee, Jong Man, Beloit
Leonovicz, Peter, Madison
*March, Jack F, Algoma
McCue, Gregory P, Milwaukee
*McKenna, John E, Antigo
*Miranda, Warren L, Marshfield
Myers, Carl F, Racine
Olson, Judyann C, Milwaukee
Peters, Stephen R, Woodruff
*Railey, Robert M, Lancaster
Randall, James G, Wauwatosa
*Ries, Peter Marshall, Marshfield
*Rietz, Daniel R, Madison
*Romeis, Richard J, Ladysmith
Rommel, Duane A, Wauwatosa
Rowberg, Donald L, Wauwatosa
Schulte, William J, Wood
Sharon, Mark W, Plymouth
*Siegel, Morris, Kenosha
*Strebe, Kenneth L, Mountain
*Strohm, John M, Madison
*Stueland, Dean T, Marshfield
*Sutton, Thomas M, Marshfield
Syrjamaki, Charles E, Green Bay
*Tobin, Joseph M, Eau Claire
*Travelli, Renato, La Crosse
*Weir, Gordon J, Marshfield

JULY 1982

*Alston, James A, Waukesha
*Bauer, William, Milwaukee
Baumann, Michael A, Wauwatosa
*Brousseau, Edward R, Eau Claire
Burgess, John H, McFarland
Calimlim, Jefferson N, Milwaukee
Cooke, William T, Richland Center
*Demergian, Vaughn, Madison
Dinyer, George R, Middleton
Gaskins, Reuel T, Milwaukee
Handler, Bruce, La Crosse
*Henshaw, H Cullen, Neenah
*Holmen, Gerald J, Baraboo
Jessen, Kevin A, Tomah
*Larson, Richard D, Greenwood
Maski, Ravikant, Platteville
Mc Illece, Patricia E, Madison
*Nowinski, Donald M, Wausau
Olson, Berta H, Milwaukee
*Patterson, Richard H, Milwaukee
*Scrimenti, Rudolph J, Milwaukee
*Sovine, David L, Glendale
*Swamy, Pandy G, Marshfield
*Tang, Thomas Tze-Tung, Milwaukee
Waraczynski, Susan E, Green Bay
*Webster, Stephen B, La Crosse
*Young, William W, St Croix Falls
Zeller, Frank H, Madison
*Zondlo, Joseph G, Green Bay■

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Physicians Exchange

Obstetrics-Gynecology. Position available at the Racine Medical Clinic, a progressive cluster corporation of 25 physicians. Excellent benefits, unlimited earnings and a fulfilling practice offered. Please contact: Roger D Lacock, Administrator, Racine Medical Clinic, 5625 Washington Ave, Racine, Wis 53406; ph 414/886-5000. 9tfn/82

General Surgeon. Small, rural JCAH hospital located in beautiful Hidden Valleys region of Southwestern Wisconsin seeks full-time surgeon. Population base of 12,000 provides opportunity with first year guarantee to build practice while enjoying pleasures of country living. Send CV or contact A Lagatta, CEO, St Joseph's Memorial Hospital, 400 Water Ave, Hillsboro, Wis 54634; ph 608/489-2211. 9/82

Family Practice position available with an 18-member multispecialty group corporate practice. Modern clinic facility in Northeastern Wisconsin city of 100,000 enjoying a healthy and stable economy. Excellent recreational, educational, hospital, civic advantages. Please call collect or write: W J Mommaerts, Clinic Manager, West Side Clinic, SC, 1551 Dousman St, Green Bay, Wis 54303; ph 414/494-5611. 8-11/82

Family Physician to join three Board certified family physicians in a young and growing medical practice in Central Minnesota. The practice is orientated toward Family Practice Medicine and located centrally in the state with quick access to the Minneapolis-St Paul area. Both practices are a short distance from the St Cloud area, and our physicians use the St Cloud Hospital for hospitalization of their patients. Cultural and recreational activities are abundant in this area of Minnesota. The salary and fringe benefits are open and negotiable. If interested, please contact Thomas J Newton, MD, Medical Director, or contact Daryl G Mathews, Administrator, at either the St Joseph or Cold Spring Medical Clinics, 26 North Red River Ave, Cold Spring, Minnesota 56320; or call collect (612) 685-8641 or (612) 363-7765 in St Joseph, Minnesota. 7-10/82

Anesthesiologist, Wisconsin-born. Graduate University of Wisconsin Medical School, 1980. Currently training in New England desires practice in Wisconsin. Trained in all types of anesthesia. Available August 1983. Contact Dept 506 in care of the Journal. 8-10/82

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Plastic Surgeon and Dermatologist positions available with an 18 member multispecialty group corporate practice. Modern clinic facility in Northeastern Wisconsin city of 100,000 enjoying a healthy and stable economy. Excellent recreational, educational, hospital, civic advantages. Please call collect or write: W J Mommaerts, Clinic Manager, West Side Clinic, sc, 1551 Dousman St, Green Bay, Wis 54303; ph 414/494-5611. 9-12/82

Obstetrician/Gynecologist to join well established general surgeon. On-call coverage malpractice and other expenses paid. Clinic one block from hospital. Superb hunting, fishing, and skiing facilities within a mile area. Initial salary with excellent fringe benefits including pension and profit sharing plan. Option to buy in practice later on. Position available immediately. Contact Dept 505 in care of the Journal. 9-10/82

Family physician and physicians from other specialties to join Board certified surgeon. Clinic within a block from hospital. No initial expense. Fully paid malpractice and health insurance. Salary with excellent fringe benefits. Option to buy in practice later on. Position available immediately. Contact Dept 507 in care of the Journal. 9-10/82

OB/GYN Specialists. Enjoy the security of group practice with the freedom of independent practice. If you are Board certified or Board eligible in OB/GYN, we have an interesting opportunity for you. Two specialists are needed immediately to form an independent OB/GYN practice in a very desirable Northern Wisconsin community with a drawing population of 70,000. Active practice assured. All major specialists available for consultation. Business and technical advice will be provided. Outstanding personal benefit programs available. Good income potential. New 35 million dollar hospital. For further information write: Administrator, PO Box 1646, Wausau, Wisconsin 54401. 9-11/82

Ideal practice opportunities for Family Practice and Internal Medicine in scenic Kettle Moraine area, Plymouth, Wisconsin. Less than one hour drive from Milwaukee, 60 miles from Green Bay. Service community of 20,000. Modern JCAH hospital and 60-bed nursing home. Family-oriented community with good industrial base. Please contact: Peter R Strub, Coordinator, Physician Recruitment Committee, Plymouth Hospital, Inc, 901 Reed St, Plymouth, Wis 53703; ph 414/803-1771. 8/82*

Pediatric, Family Practice positions available in 13-member multispecialty group. Inquire: General Clinic of West Bend, Inc, 279 S 17th Ave, West Bend, Wis 53095. 2tfn/82

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Laurie Glowac or Fred Moskol
New Physicians for Wisconsin
University of Wisconsin Department of Family Medicine
777 South Mills Street, Madison, Wisconsin 53715
Phone: 608/263-4095

1-12/82

Physicians Exchange

continued

Doctors needed—in Wisconsin. All specialties and all locations. For confidential information, mail your CV to: Medicus, 1525 Wisconsin Ave, Grafton, WI 53024. 6tfn/82

Wausau Medical Center, SC, a 50-physician multispecialty group has openings for physicians in the following specialties: *Neurology, Otolaryngology, Cardiology* and *General Surgery* with a fellowship training in *Peripheral Vascular Surgery*. Competitive first-year salary, incentive plan thereafter. Comprehensive fringe benefits. New facility near new hospital. Located in beautiful, quiet, central Wisconsin, metropolitan area of 65,000. Recreational opportunities abundant. For more information contact: K L Day, MD, Wausau Medical Center, SC, 2727 Plaza Drive, Wausau, Wis 54401, or call collect 715/847-3351. 6tfn/82

General Surgeon. Enjoy the security of group practice with the freedom of independent practice. If you are a Board certified or Board eligible general surgeon, we have an interesting opportunity for you. A general surgeon is needed immediately to form an independent practice in a very desirable Northern Wisconsin community with a drawing population of 100,000. All major specialists available for consultation. A growing community hospital with 240-beds with excellent medical and surgical subspecialty representation. Opportunities for endoscopy and peripheral vascular surgery also exist. For further information write: Administrator, PO Box 1646, Wausau, Wis 54401. 7-9/82

Family Practice Physician to share fully equipped medical office in central Wisconsin city. Opportunity for partnership and eventual purchase of practice. Excellent recreational, educational, hospital, and civic advantages. Send curriculum vitae to Dept 503 in care of the Journal. 6tfn/82

Family Physician to join our group of six Board certified family practitioners and Board certified general surgeon. Liberal vacation and educational allowances. Competitive salary first year with incentive bonus, and full membership after one year. Blue Earth is a farming town of 4000 in Southern Minnesota with a drawing area of 25,000. 35-bed hospital with adjoining clinic facilities. Complete opportunity for an aggressive young family physician. Please contact Marjeane Werner or Thomas E Watts, MD, Blue Earth Medical Center, Ltd, 520 South Galbraith, Blue Earth, Minn 56013; ph 507/526-7371. 8-12/82; 1/83

Obstetrics-Gynecology position available with an 18-member multispecialty group corporate practice. Modern clinic facility in Northeastern Wisconsin city of 100,000 enjoying a health and stable economy. Excellent recreational, educational, hospital, civic advantages. Please write: W J Mommaerts, Clinic Manager, West Side Clinic, SC, 1551 Dousman St, Green Bay, WI 54303. 6-9/82

Family Physician for Locum Tenens. Experienced Board certified family physician for 9 years on the full time faculty of the University of Wisconsin Medical School, available for Locum Tenens, all areas of Wisconsin. Contact: Rudolph C Hecht, MD, 312 Newcastle Way, Madison, Wis 53704; ph (home) 608/249-5201. p9/82

NATIONWIDE PHYSICIAN PLACEMENTS

We are seeking physicians on behalf of clients in various parts of the country. Opportunities exist in many specialties. For information call Steve Hymes (collect) at 608/271-8811.

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Established Mental Health clinicians in private practice on Madison's far West side seek to share spacious and unique office suite with psychiatrist. please contact Teresa Hayden, PhD, Clinical Psychologist, 6510 Schroeder Rd, Madison, Wis 53711; ph 608/274-2098. p9/82

OB-GYN Infertility practice for sale. Milwaukee area. Fully equipped office. Gross over $150,000. Terms negotiable. Call or write: A Chatterjee, MD, 8511 W Lincoln, West Allis, Wis 53227; ph 414/543-9580. 9/82

Locum Tenens opportunity available 9/30/82. Temporary full time position to carry patient load of exiting physician. Potential for permanent practice if desired. Excellent pay arrangements and liability insurance. If interested please contact: Norman C Schroeder, MD, Park Medical Center, Ltd, 601 North 8th St, Manitowoc, Wis 54420; ph 414/682-4646. 9-11/82

Family Practice, Sparta Clinic, Ltd, Sparta, Wis, a six physician group offers an excellent opportunity for a family physician willing to do some obstetrics. The Clinic is located one block from St Mary's Hospital and 25 miles from a major referral center. Salary guarantee available plus potential for bonus based on work done. Clinic pays all insurance and pension and profit sharing after one year. MD or DO. Contact Thomas E Flood, Administrator, Sparta Clinic, Ltd, PO Box 250, Sparta, Wis 54656; ph 608/269-6731. 7-9/82

Family physician, Board Certified or Eligible, to join four-man family practice group in northwest Wisconsin. First-year guaranteed salary. New clinic building located adjacent to 46-bed hospital, in the heart of Wisconsin's vacationland. Call shared with other family practice physicians in area, weekend coverage contracted. Jeanne Chamberlain, Adm, Spooner Clinic Ltd, 707 Ash St, Spooner, Wis 54801. Ph 715/635-2151. 7-10/82

The Racine Medical Clinic, a progressive cluster corporation of 25 physicians, is currently seeking an orthopedic surgeon and an invasive cardiologist. Full benefits, unlimited earnings and a full and exciting practice are offered. Please contact: Roger D Lacock, Administrator, Racine Medical Clinic, 5625 Washington Ave, Racine, WI 53406; ph 414/886-5000. 1tfn/82

Family Practitioner needed to join multi-specialty group of 33 physicians dedicated to primary care in East Central Wisconsin community. City population 48,000, drawing area 100,000. Attractive income arrangements, association membership possible after one year, pension and profit sharing, extensive fringe benefits. Contact R B Windsor, MD, 1011 North 8th St, Sheboygan, Wis 53081; ph 414/457-4461. 5tfn/82

Adult Psychiatrist to join well established group in a community of 50,000 with large referral area. Two excellent hospitals, University, and industrial area. Salary—open. Excellent benefits. For further information contact: J M Tobin, MD, Northwest Psychiatric Clinic, Eau Claire, Wis 54702; ph 715/834-2751. 8-12/82; 1/83

Surgeon with Thoracic general vascular training, Ophthalmologist, and ENT, to join a progressive multispecialty group of 17 physicians consisting of General/Family Medicine, General Surgery, Internal Medicine, OB-GYN, Ophthalmology, Orthopaedic Surgeon, Pediatrics/Adolescent Medicine, and Radiology. Subspecialties include: Pathology, Vascular Surgery, Cardiovascular Diseases, Gastroenterology and Endoscopy. We are located in a fast growing, scenic, lake country area between Milwaukee and Madison and can offer excellent hospital, schools, and recreational facilities. Full fringe benefit package. Contact: James F Dowd, Admin, Wilkinson Clinic SC, 915 East Summit Ave, Oconomowoc, Wis 53066; ph 414/567-4433. 9tfn/81

Milwaukee, Wisconsin Opportunity. Expanding from an existing complement of forty-five practitioners, Southeastern Wisconsin's premier multispecialty clinic seeks a practitioner (family practice, industrial medicine, or general internal medicine) to direct the activities of our newly established Urgent Care Center. We offer a competitive first year starting salary plus further incentive compensation based upon productivity. Corporately provided benefits include malpractice, health, life, and group and individual disability insurances; vacation and meeting time allowances; etc. To learn more about our opportunity, to receive a copy of our physician recruiting brochure, and to receive our immediate consideration, please submit your CV to Mr Robert P Thompson, Administrator, Milwaukee Medical Clinic, SC, 3003 West Good Hope Road, PO Box 17300, Milwaukee, Wisconsin 53217. 8-9/82

Internist wanted. Board certified or eligible with/without subspecialty, to practice in conjunction with a 6-member Internal Medicine Department in a 22-member multispecialty group. Present subspecialties: Gastroenterology and cardiology. The group is in Southeastern Wisconsin, in a city of 100,000 between two major metropolitan areas of greater than one million. If interested, please send CV to: Stephen L Wagner, Kurten Medical Group, 2405 Northwestern Ave, Racine, Wis 53404. All inquiries will be kept confidential. 3tfn/82

Family Practice Physician/or Primary Care Oriented Internist to join two family practice physicians and a Board certified surgeon in a group practice. Located in a community of 2,500 in southwest Minnesota. This medical clinic is supported by a modern 30-bed acute care hospital and 138-bed skilled long-term care facility. Guaranteed first year income, will pay travel expenses for interview. Interested physicians send curriculum vitae to William Wilson, Administrator, Springfield Community Hospital, PO Box 146, Springfield, Minn 56087 or call collect 507/723-4215 for more information. 5-10/82

Family Practice/Urgent Care position immediately available in a 42-member multispecialty group corporate practice to direct and operate evening and weekend Urgent Care facility. Beautiful clinical facility in Glendale, Wisconsin, a northern Milwaukee suburban city. Guaranteed first-year salary, stockholdership and partnership after one year, plus profit-sharing. To learn more about our opportunity and to receive our immediate consideration, please submit your CV to Mr James A Heinz, Assistant Administrator, Milwaukee Medical Clinic, SC, 3003 West Good Hope Rd, PO Box 17300, Milwaukee, Wis 53217. 8-10/82

Family Physician or Internist to join three-man family and general practice group in the heart of North Central Wisconsin vacationland. First year guaranteed salary. Numerous fringe benefits. Clinic across from hospital. Send CV to: O M Francisco, MD, 221 E Washington Ave, Tomahawk, Wis 54487; ph 715/453-2147. 5tfn/82

Wanted. Board certified or eligible orthopedic surgeon to practice in conjunction with a 5-member surgery department in a 22-member multispecialty group. Present surgical specialties: thoracic and vascular surgery, general surgery and urology. The group is located in the upper midwest, in a city of 100,000 between two major metropolitan areas of greater than one million. If interested, please send CV to: Stephen Wagner, Kurten Medical Group, SC, 2405 Northwestern Ave, Racine, Wis 53404. All inquiries will be kept confidential. 12tfn/80

Board eligible/Certified FP's needed at multiple locations in Northeastern rural Wisconsin. Financial assistance available and negotiable. Excellent locations, communities, recreation areas. Contact J Schumacher, Administrator, Calumet Memorial Hospital, Chilton, Wis 53014; ph 414/849-2386. 7-9/82

Medical Facilities

Family Practice and Clinic Building in Spring Valley, Wisconsin, (town is 45 minutes drive to St Paul; one hour to Minneapolis). Building with 3 examining rooms, x-ray room with equipment, laboratory, coffee room, waiting room, and a doctor's office. Sales include all furniture, equipment, supplies, 2 refrigerators. Big lot with parking area for doctors and many cars. Available immediately. All these for $89,000. Should see to appreciate. Please call 715/778-5591 (5:30 pm to 7:30 pm); 715/778-4415 after 7:30 pm and week-ends. 9-11/82

Established solo practice in internal medicine for sale. Available immediately. Located in Milwaukee area. For information call 414/332-9006 or contact Dept 509 in care of the Journal. g9/82

Space sharing opportunity. Enjoy your independent practice in a fully equipped/fully staffed new medical facility in Waukesha, Wisconsin. Rapidly expanding area. Located just six minutes from two excellent hospitals. Arrangements open. Contact Westmound Medical Clinic; ph 414/549-9100. 9-10/82

Medical office space for lease. New Swiss chalet style building in fast growing community. Needs family practitioner, pediatrician, etc. Building has dentist and pharmacy. Very reasonably priced in Waukesha County near expressway. Info: call 414/781-1155. 7tfn/82

Medical equipment for sale, including a Craig x-ray unit, perfectly suited for a physician's office, and laboratory, ECG and exam room furnishings and equipment, plus office, lounge, and waiting room furniture, all in like-new condition. Call Administrator, 414/271-6800 for specific information. 8-9/82

For Sale: Ritter motorized exam table, 3 exam tables, EKG, 5 surgical lights, medical refrigerator, sterilizer, magnifying eye light, 3 floor blood pressure machines, 2 surgical instrument stands, 2 x-ray view boxes, dryer, many other small items. Physician retired. Good condition, very reasonable. 521-8th St, So, Wisconsin Rapids, Wis 54494; ph 715/423-3500. 8-10/82

FAMILY PHYSICIAN

The Duluth Clinic, Ltd., a 95-physician multispecialty comprehensive regional medical center, is actively seeking one or two family physicians for one of its existing metropolitan satellite facilities. State of the art diagnostic equipment, surgical suites and hospital facilities are available.

Qualifications required include board certification or eligibility in family practice.

Metropolitan area includes 125,000 people, with regional referral base of approximately 500,000. Ample outdoor recreational and cultural opportunities readily available. Please respond with complete curriculum vitae to:

Stan E. Salzman
Executive Director
The Duluth Clinic, Ltd.
400 East Third Street
Duluth, Minnesota 55805

The Duluth Clinic, Ltd.

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Medical Facilities

continued

Medical Practice For Sale. Family practice available due to illness. Western Milwaukee County. Please call Bob Koehne at 414/545-0440. 9/82

FOR SALE: Burroughs L-3000 minicomputer posting machine. Excellent condition, used only three years. Contact Associated Physicians, Fond du Lac, Wisconsin: 414/922-3700. 8-9/82

Miscellaneous

Physicians Signature Loans to $50,000. Up to 7 years to repay. No prepayment penalties. Prompt, courteous service. Physicians Service Assn, Atlanta, GA. Toll-Free (800) 241/6905. 4tfn/82*

Medical receptionist, light typing, records management. Part-time or job sharing arrangement wanted. Elementary teaching experience, familiar with handicapping conditions, west or south Madison preferred. References. Jean Maxine Clausen, 4318 Tokay Blvd, Madison, Wis 53711; phone 233-5170. p9/82

Physicians, is your business practice as proficient as your medical practice? Wisconsin Medical Management Services may be able to improve your profits by providing professional management and consulting services. Over thirteen years experience. Contact Dept 508 in care of the Journal for further information. p9/82

For sale: 1933—six Plymouth in excellent condition, all original, dark blue and black. Presently being shown in Bruce Mohs Antique Auto Museum in Riley, Wisconsin, $7800. Antique professional pool table, 1920s, tiger oak, like new condition. Valued $6000. Asking $3600. Phone Madison 608/238-8836. 9/82

Real Estate

A SAFE TAX SHELTER. Land ownership offers more. The new A.C.R.S. (Accelerated Cost Recovery System). Depreciation + Inflationary Appreciation + Investment Credits, all put money into your pocket. FAITH REALTY—Est 1960, Farm Specialist-Tax Consultant, Whitewater, Wis 53190 (414/473-2779). PS: Who do you know who wants to buy a farm? 9-12/82; 1-2/83

Meetings/CME Courses

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates: 40¢ per word, with a minimum charge of $16.00 per listing. BOXED LISTINGS: $32.00 per column inch. COPY DEADLINE for Continuing Medical Education listings is tenth of the month preceding the month of publication; e.g., copy for the August issue is due by July 10. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 800/362-9080. For listing of other meetings see the Special Issue of the Journal of the American Medical Association: Continuing Education Courses for Physicians for period Sept 1, 1982 through Aug 31, 1983.

WISCONSIN

OCTOBER 1-2, 1982: *Clinical Neuroscience,* Madison. Sponsored by Allied Health Program Unit, University of Wisconsin-Extension. 12 University of Wisconsin-Extension Continuing Education Hours approved. Info: Sara Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

OCTOBER 5, 1982: *Psychosocial Treatment for Schizophrenias,* Wisconsin Union 800 Langdon St, Madison. Sponsored by University of Wisconsin-Extension, Health and Human Services Area, Continuing Education in Mental Health. Approved 6 credit hours of Category 1 of the AMA-PRA. Info: Bernadine Eve Bednarz, MSW, 414 Lowell Hall, 610 Langdon St, Madison, Wis 53706; ph 608/263-4431.

OCTOBER 6, 1982: *Psychosocial Treatment for Schizophrenias,* The Hotel Astor Conference Center, 924 E Juneau Ave, Milwaukee. Sponsored by University of Wisconsin Extension, Health and Human Services Area, Continuing Education in Mental Health. Approved 6 credit hours of Category I of the AMA-PRA. Info: Bernadine E Bednarz, 414 Lowell Hall, 610 Langdon St, Madison, Wis 53706; ph 608/263-4431.

OCTOBER 8, 1982: *Staking Your Claim on Wisconsin's Health Education Future,* Wisconsin Center, Madison. Guest speakers: Charles Althafer, Atlanta, Ga; Dr Alan Henderson, St Louis, Mo; Beverly Blue, Lubbock, Tex; Tom Dewar, St Paul, Minn; Robert Harris, Milwaukee; Carl Selbo, Madison; Robert Jecklin, La Crosse; and Jon Hisgen, Pewaukee. Fee: $50. Approved .7 CEU credits. Info: Carrie Pearson, Consumer Health Education, 215C Main Hall, UW-La Crosse, La Crosse, Wis 54601. 9/82

OCTOBER 9, 1982: *The Medical Consequences of Nuclear Weapons and Nuclear War,* Milwaukee Hyatt Recency, 333 West Kilbourn Ave, Milwaukee. Sponsored by Physicians for Social Responsibility in conjunction with The Department of Preventive Medicine, The Medical College of Wisconsin. Approved credit hours in Category 1 of ACCME. Info: Physicians for Social Responsibility, Inc, Southeastern Wisconsin Chapter, 1610 E Newport Ave, Milwaukee, Wis 53211.

OCTOBER 9, 1982: Second Annual Meeting of the *Wisconsin Association of Senior Physicians,* at State Medical Society Headquarters in Madison. Info: Norman Clausen, MD, President, WASP, PO Box 1109, Madison, Wis 53701.

OCTOBER 14-15, 1982: *Aging and Illness in Primary Care: The Second Symposium on Basic and Clinical Science Foundations,* Madison. Sponsored by University of Wisconsin-Extension, Continuing Medical Education; University of Wisconsin Medical School Departments of Medicine and Family Medicine and Practice and Wisconsin Regional Geriatric Center, Milwaukee. AMA Category I, AOA Category 2-D, AAFP, University of Wisconsin CEU's—all 14 hours. Fee: $200/physicians, $125/nurse, residents, others. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

OCTOBER 14, 1982: *2nd Annual Fall Cardiology Conference,* Madison. Sponsored by Madison General Hospital ECG Committee. Approved 4 credit hours of Category 1 of AMA-PRA and AAFP. Fee. $25.00. Info: Howard B Christensen, CME, 202 South Park St, Madison, Wis 53715; ph 608/267-6386.

OCTOBER 14-15, 1982: *Wisconsin ACEP-EDNA Fall Symposium,* Midway Motor Lodge, Milwaukee-Brookfield. Fee: $125/ACEP members; $175/non-members; $50/residents. Approved 12 credit hours CME. Info: James Williams, MD, 1836 South Ave, La Crosse, Wis 54601.

OCTOBER 15-16, 1982: *The Injured Child Symposium,* St Marys Hospital Medical Center, Madison. Guest Faculty: Dr Robert M Filler, Surgeon in Chief, Hospital for Sick Children, Toronto, Canada; Dr Jay L Grosfeld, Director, Section of Pediatric Surgery, James Whitcomb Riley Hospital for Children, Indianapolis, Ind; Dr Dale G Johnson, Chief of Surgery, Primary Children's Medical Center, Salt Lake City, Utah. Approved for 10 prescribed hours by AAFP. Info: Barbara Nichols, Director, Inservice Education Dept, St Marys Hospital Medical Center, 707 South Mills St, Madison, Wis 53715; ph 608/251-6100.

OCTOBER 15, 1982: *Informal Piagetian Cognitive Assessment,* at Mendota Mental Health Institute, Madison. Presented by Gary Gill, PhD and Peggy Rosin, MS, CCC-SP, Dept of Communicative Disorders, University of Wisconsin-Madison. Contact Training Dept, Mendota Mental Health Institute. 301 Troy Drive, Madison, Wis 53704; phone 608/244-2411.

OCTOBER 16, 1982: Wisconsin Radiological Society, Concourse Hotel, Madison.

OCTOBER 19, 1982: *Suicide Assessment and Intervention,* Stevens Point. Sponsored by University of Wisconsin-Extension, Dept of Allied Health and University of Wisconsin-Extension, Dept of Mental Health. AMA Category I, 6 hours; University of Wisconsin-Extension Continuing Education Hours, 6 hours. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

OCTOBER 20, 1982: *Suicide Assessment and Intervention,* Beaver Dam. Sponsored by University of Wisconsin-Extension, Dept of Allied Health and University of Wisconsin-Extension, Dept of Mental Health. AMA Category I, 6 hours; University of Wisconsin-Extension Continuing Education Hours, 6 hours. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

OCTOBER 20, 1982: Milwaukee Ophthalmological Society Fall Meeting at University Club in Milwaukee. Info: Michael R McCormick, MD, Secretary, 102 East Main St, Waukesha, Wis 53186 (phone: 414/547-3352).

OCTOBER 21-23, 1982: *Sick, Criminal, or Nuisance? How to Deal with the Mentally Ill Lawbreaker in the Community,* Inn on the Park, Madison. Sponsored by the University of Wisconsin-Extension Continuing Medical Education; University of Wisconsin School of Medicine, Dept of Psychiatry in cooperation with Continuing Legal Education; University of Wisconsin-Extension and the State of Wisconsin Justice Department. Info: Ann Bailey, Admin, CME, 454 WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2854.

OCTOBER 22, 1982: *Normal Aging,* presented by Mendota Mental Health Institute Staff. Contact Training Dept, MMHI, 301 Troy Drive, Madison, Wis 53704; phone 608/244-2411.

NOVEMBER 2-3, 1982: *Group Dynamics in a Treatment Team,* presented by Janice Robertshaw, MEd, Training and Management Consultant, at Mendota Mental Health Institute, Madison. Contact Training Dept, MMHI, 301 Troy Drive, Madison, Wis 53704; phone 608/244-2411.

STATE MEDICAL SOCIETY OF WISCONSIN
Dates and Locations of Annual Meetings
1982-1992

All meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) and the new Hyatt Regency as the headquarters hotel with the exception of 1985, when the meeting will be held at the LaCrosse Convention Center.

1983—Mar 24-26	**1988—Apr 28-30**
1984—Mar 29-31	**1989—Apr 13-15**
1985—Apr 25-27	**1990—Apr 26-28**
1986—Apr 17-19	**1991—Apr 18-20**
1987—Mar 26-28	**1992—Apr 23-25**

Meeting days will be Thursday and Friday; the first session of the House of Delegates will convene on Thursday, the second and third on Friday. Scientific programming will be on Friday and Saturday.

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701. Local telephone: 257-6781; toll-free in Wisconsin: 1-800/362-9080.

ALCOHOLISM UPDATE: A Problem-Solving Seminar for Physicians

Sponsored by
Committee on Alcoholism and Other Drug Abuse
State Medical Society of Wisconsin

November 18, 1982: Stevens Point

8:55	Welcome, *Michael Gordon, MD*
9:00	Pathophysiology of Alcoholism, *Herbert White, DO*
9:30	Disease Concept of Alcoholism, *Michael Gordon, MD*
10:00	Detox, *Craig Larson, MD*
10:45	Multiple Chemical Dependency, *Herbert White, DO*
11:15	Special Problems of the Alcoholic Woman, *Pauline Jackson, MD*
11:45	The Family Illness, *Michael Gordon, MD*
12:15	Luncheon Program: What Do Alcoholics Anonymous and Al-Anon Have to Offer?
1:15	Adolescent Chemical Dependency, *Roland E Herrington, MD*
1:45	Psychiatric Problems of Alcoholics, *Craig Larson, MD*
2:15	Medical-Legal Issues, *H B Maroney, JD*
3:00	Confrontation and Motivation to Seek Help, *Pauline Jackson, MD*
3:30	Treatment and Community Resources, *Herbert White, DO*
4:00	Some Do's and Don'ts, Panel Discussion

Approved 6 credit hours of Category 1 of AMA-PRA and AAFP. Fee: $55/member of SMS; $7.50 for resident; $80 for non-members.

Info: State Medical Society of Wisconsin, PO Box 1109, Madison, Wis 53701; or call Bill Wendle or Arlene Meyer, 1-800/362-9080 or 608/257-6781.

NOVEMBER 4-6, 1982: *4th Annual Respiratory Critical Care Symposium: Update on Current Concepts,* Inn on the Park Hotel, Madison. Sponsored by the University of Wisconsin-Extension Dept of Continuing Medical Education; University of Wisconsin Dept of Nursing; Pulmonary Section of School of Medicine; and Respiratory Therapy Dept and Center for Trauma and Life Support. Credit: AMA, University of Wisconsin Continuing Education hours, AOA, AAFP, College of Emergency Physicians—all 18 hours. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

NOVEMBER 5, 1982: Wisconsin Orthopaedic Society, Olympia Resort, Oconomowoc.

NOVEMBER 5-6, 1982: *Wisconsin Neurosurgical Society,* Marriott Inn, Brookfield.

WISCONSIN SPECIALTY SOCIETY MEETINGS: 1982-1983

Wisconsin Radiological Society, Oct 16, 1982, Concourse Hotel, Madison

Wisconsin Orthopaedic Society, Nov 5, 1982, Olympia Resort, Oconomowoc

Wisconsin Allergy Society, Nov 6-7, 1982, Pioneer Inn, Oshkosh

Wisconsin Neurosurgical Society, Nov 5-6, 1982, Marriott Inn, Brookfield

Wisconsin Chapter: American College of Emergency Physicians, Oct 14-15, 1982, Midway Motor Lodge, Brookfield

Wisconsin Orthopaedic Society, Nov 5, 1982, Olympia Resort, Oconomowoc

Wisconsin Chapter: American College of Surgeons, Dec 4, 1982, Hyatt-Regency, Milwaukee

Wisconsin Chapter: American Academy of Pediatrics, May 19-20, 1983, Pioneer Inn, Oshkosh

Wisconsin Academy of Family Physicians, June 16-18, 1983, Lake Geneva

* * *

SPECIALTY SOCIETY MEETINGS TO BE HELD IN CONJUNCTION WITH SMS ANNUAL MEETING, March 24-26, 1983, Milwaukee

Wisconsin Allergy Society
Wisconsin Orthopaedic Society
Wisconsin Psychiatric Association
Wisconsin Society of Internal Medicine
Wisconsin Society of Pathologists
Wisconsin Society of Physical Medicine and Rehabilitation
Wisconsin Society of Plastic Surgeons
Wisconsin Society for Preventive Medicine
Wisconsin Society of Radiation Oncologists
Wisconsin Surgical Society

NOVEMBER 6-7, 1982: Wisconsin Allergy Society, Pioneer Inn, Oshkosh.

NOVEMBER 8, 1982: *Suicide Assessment and Intervention,* Milwaukee. Sponsored by University of Wisconsin-Extension, Dept of Allied Health and University of Wisconsin-Extension, Dept of Mental Health. AMA Category 1, 6 hours; University of Wisconsin-Extension Continuing Education Hours, 6 hours. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

NOVEMBER 9, 1982: *Suicide Assessment and Intervention,* Kenosha. Sponsored by University of Wisconsin-Extension, Dept of Allied Health and University of Wisconsin-Extension, Dept of Mental Health. AMA Category I, 6 hours; University of Wisconsin-Extension Continuing Education Hours, 6 hours. Info Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

NOVEMBER 10, 1982: *Maintaining the Chronically Mentally Ill in the Community*—the Nurse's Role, presented by Staff of the Mendota Mental Health Institute's Program for Assertive Community Treatment (PACT). Contact Training Dept, MMHI, 301 Troy Drive, Madison, Wis 53704; phone 608/244-2411.

NOVEMBER 13-14, 1982: *Therapeutics 1982,* Madison. Sponsored by University of Wisconsin-Extension, Dept of Continuing Medical Education; and University of Wisconsin School of Medicine, Dept of Medicine. Credit: University of Wisconsin-Extension CEU's, AMA Category I, AAFP and AOA approved for—all 9 hours. Info: Sarah Z Aslakson, Continuing Medical Education, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

NOVEMBER 16, 1982: *Family Therapy with Troubled Adolescents,* presented by Larry Kogan, Family Treatment Unit, St Louis County Juvenile Court, at Mendota Mental Health Institute in Madison. Contact Training Dept, MMHI, 301 Troy Drive, Madison, Wis 53704; phone 608/244-2411.

NOVEMBER 18, 1982: *Alcoholism Update; A Problem-Solving Seminar for Physicians,* Sentry Insurance Headquarters, Stevens Point. Sponsored by The Committee on Alcoholism and Other Drug Abuse, State Medical Society of Wisconsin. (See further details elsewhere in this section)

NOVEMBER 19, 1982: *Working with the Person with Organic Brain Syndrome,* presented by Mendota Mental Health Institute Staff. Contact Training Dept, MMHI, 301 Troy Drive, Madison, Wis 53704; phone 608/244-2411.

DECEMBER 3-4, 1982: *2nd Annual Coronary Artery Disease Update,* Madison. Sponsored by University of Wisconsin School of Medicine, Dept of Medicine, Division of Cardiology and Departments of Surgery, Division of Thoracic and Cardiovascular Surgery; and University of Wisconsin-Extension, Dept of Continuing Medical Education. AMA Category I; AOA Category 2-D, AAFP, University of Wisconsin CEU's. Info: Sarah Z Aslakson CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

DECEMBER 4, 1982: *Wisconsin Chapter, American College of Surgeons,* Hyatt Regency, Milwaukee.

JANUARY 12-14, 1983: *Clinical Cancer Conference,* The Telemark Lodge, Cable. Sponsored by Marshfield Clinic, Duluth Clinic, Wisconsin Cancer Society and the Minnesota Cancer Society. Info: Office of Medical Education, 1000 North Oak Ave, Marshfield, Wis 54449; ph 715/387-5207.

FEBRUARY 16-18, 1983: *Medical/Surgical Update '83.* The Telemark Lodge, Cable. Sponsored by Marshfield Clinic. Info: Office of Medical Education, 1000 North Oak Ave, Marshfield, Wis 54449; ph 715/387-5207.

OTHERS

OCTOBER 14-17, 1982 (MICHIGAN): Regional Meeting, American College of Physicians, Traverse City Hilton, Traverse City. Info: Arnold R Axelrod, MD, FACP, Chairman, Dept of Medicine, Sinai Hospital, 6767 West Outer Dr, Detroit, MI 48235. g9/82

OCTOBER 15-16, 1982 (MISSOURI): Regional Meeting, American College of Physicians, Breckenridge, St Louis. Info: David M Kipnis, MD, FACP, Washington University School of Medicine, 600 S Euclid, St Louis, MO 63110. g9/82

OCTOBER 22, 1982 (NEW YORK): *Sleep Disorders in Children: Sids—Sleep Apnea, Research, and Evaluation,* Long Island Jewish-Hillside Medical Center, New Hyde Park. Sponsored by Department of Otolaryngology, Long Island Jewish-Hilldside Medical Center, New Hyde Park, New York. Program chairman/ Mark N Goldstein, MD. Fee: $50. Approved 5 credit hours of Category 1 ACCME. Info: Ann J Boehme, Continuing Education Coordinator, Long Island Jewish-Hillside Medical Center, New Hyde Park, New York 11042; ph 212/470-2114. 9/82

NOVEMBER 1-4, 1982: (California): 67th Annual Scientific Assembly of Interstate Postgraduate Medical Association at Town and Country Hotel, San Diego. Approved 24 hours of Category 1 and 4 hours of Category 5 credit of AMA-PRA. Info: Interstate Postgraduate Medical Association, PO Box 1109, Madison, Wis 53701.

NOVEMBER 3, 1982 (NEW YORK): *Anorexia Nervosa; Causes and Cures,* Long Island Jewish-Hillside Medical Center, New Hyde Park, NY. Sponsored by The Division of Adolescent Medicine; The Department of Pediatrics, Long Island Jewish-Hillside Medical Center, and the Health Sciences Center, State University of New York at Stony Brook. Approved 7 credit hours in Category 1 of ACCME. Info: Ann J Boehme, Continuing Education Coordinator, Long Island Jewish-Hillside Medical Center, New Hyde Park, New York 11042; ph 212/470-2114. 9/82

DECEMBER 8-10, 1982 (Illinois): *Neurology for the Non-Neurologist,* The Westin Hotel, Chicago. Sponsored by Rush-Presbyterian-St Luke's Medical Center. Approved 20 credit hours of Category 1 AMA-PRA. Info: University of Office of Continuing Education, Rush-Presbyterian-St Luke's Medical Center, 600 South Paulina, Chicago, IL 60612; ph 312/942-7095. 8-11/82

JANUARY 8-14, 1983 & FEBRUARY 28-MARCH 4, 1983 (COLORADO): *Current Concepts in Pain Management,* Steamboat Springs, CO. Spouse may attend tax and retirement fund management program following medical lectures (and deduct expenses). Fee: $250 (spouse $100). Info: Donald A Berman, MD, Program Director, Current Concept Seminars, 3301 Johnson St, Hollywood, FL 33021; ph 305/989-6650. p9/82

FEBRUARY 7-11, 1983 (IDAHO): *Scientific/Ski Meeting:* 36th Annual Meeting of Northwestern Medical Association, Sun Valley, Idaho. Transplants-implants, general medicine subjects, ski-injury prevention, high-altitude physiology and financial planning will be discussed by experts. Approved 10 credits Category 1 ACCME. Registration, 3 to 5 pm on Feb 7, 1982, Challenger Inn, Sun Valley. Non-members registration/$100. Info: Norman Christensen, MD, 2456 Buhne St, Eureka, CA 95501; ph 707/ 443-2248. 9-10/82

FEBRUARY 23-MARCH 1, 1983 (Hawaii): *Adolescent/ Young Adult Medicine,* Wailea Beach Hotel, Maui, Hawaii. 20 hours. Sponsored by Hurley Medical Center, Dept of Continuing Education, 1 Hurley Plaza, Flint, Mich 48502; ph 313/766-0142. 8-9/82

MARCH 6-9, 1983 (MISSOURI): Sixth National Conference on Rural Primary Care, at Radisson-Muehlebach Hotel, Kansas City. Sponsored by National Rural Primary Care Association and cosponsored by over a dozen national health-related organizations. Hosted by American Academy of Family Physicians. Of interest to anyone involved in rural health care: administrators, physicians, nurses, NPs, PAs, health educators, health planners, students, consultants, etc. Info: Carrie Samuel, Conference Coordinator, NRPCA office, Box 1211, Waterville, ME 04901 (phone: 207/873-7784). g9-12/82;1/83

1983 CME Cruise/Conferences on Legal-Medical Issues— Caribbean, Mexican Riviera, Alaska, Mediterranean. 7-14 days in January, April, July, August. Seminars led by distinguished professors. Approved for 18-24 CME Category 1 credits. *Free Roundtrip Airfare on all Caribbean, Mexican, Alaskan Cruises.* Excellent group fares on finest ships. All conferences, scheduled prior to 12/31/80, conform to IRS tax deductibility requirements under 1976 Tax Reform Act. Registration limited. For color brochures and additional information contact: International Conferences, 189 Lodge Ave, Huntington Station, NY 11746; ph 516/549-0869. p9-10/82

AMA

DECEMBER 5-8, 1982: Interim AMA House of Delegates, Miami Beach, Fl.

JUNE 19-23, 1983: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 4-7, 1983: Interim AMA House of Delegates, Los Angeles, CA.

JUNE 17-21, 1984: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 5-7, 1984: Interim AMA House of Delegates, Honolulu, Hawaii. ■

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News You Can Use

By EARL THAYER, Secretary/BERNIE MARONEY, Assistant Secretary

NEW FAIR EMPLOYMENT LAW IN EFFECT. Several changes in the Wisconsin fair employment law took effect in August which may be of concern to physicians and their employees. The new law broadens and reorganizes the definition of "discrimination" and incorporates several handicapped and sex-related employment discrimination decisions by the Wisconsin Supreme Court along with recent federal law changes. Among the provisions of the new law are:

- ***Age:*** A person between 40 and 70 years of age cannot be denied employment solely on the basis of age. Previously, the upper limit was 65.
- ***Marital status:*** Persons cannot be denied employment solely because they are married, single, divorced, widowed, or separated. However, employers can prohibit individuals who work for them from supervising or being supervised by their spouses.
- ***Dress code:*** Requires employers at the time of employment to notify each employee about any hairstyle, facial hair, or clothing requirement. Note that dress and appearance codes are *not* forbidden.
- ***Handicapped employees:*** Clarifies the definition of discrimination against the handicapped. The new law prohibits denying employment solely on the basis of a person being handicapped. It prohibits employers from developing blanket rules against hiring certain types of handicapped persons. An employer may, however, take the safety of the handicapped individual or other employees into consideration.
- ***Sex:*** Included under sex discrimination in employment is a new provision prohibiting sexual harassment. Sexual harassment is defined as "unwelcome verbal or physical conduct of a sexual nature." It also includes the deliberate, repeated making of unsolicited gestures or comments, or the deliberate, repeated display of offensive sexually graphic materials which are not necessary for business purposes.

JCAH TO AMEND MEDICAL STAFF CLASSIFICATION. The Joint Commission on Accreditation of Hospitals intends to amend the classification of "medical staff" to "professional or medical staff" in its latest revision of JCAH standards. The change is necessary, according to legal counsel from the American Medical Association and the American Hospital Association—the two primary associations that make up JCAH, because of restraint of trade possibilities. It is alleged that several states have laws giving nonphysician professionals a legal right to hospital privileges, and JCAH standards must be consistent nationwide. Wisconsin does not have such a law. Needless to say, the proposed change has many physicians upset. They feel the change will open hospital doors to optometrists, clinical psychologists, nurse practitioners, chiropractors, and other nonphysician professionals. AMA President William Y Rial, MD, Swarthmore, PA, said in an article in *Medical Economics* in July that he can't guarantee that this indeed won't happen. "It's a local decision. It must be based on the individual's qualifications, and if the staff is still in doubt then the person should demonstrate his clinical ability, perhaps by observation over a period of probation. But there can't be restriction just because a person is a chiropractor or an optometrist or nurse practitioner, or whatever," Doctor Rial said. "On the other hand, we think we can still restrict credentials to those we consider best qualified for them—fully licensed physicians and dentists," he said.

WISCONSIN NURSES TO BE HONORED SEPTEMBER 19-25. The Wisconsin Nurses Association is sponsoring Wisconsin Nurses Week September 19-25, 1982 throughout the state. "Nursing: A Force in Wisconsin's Health Care" is the theme set for a statewide event. The theme highlights the active role nurses have taken during the past years in working for and providing quality health care in the state. Each of the state's hospitals, nursing homes, medical clinics, and public health agencies has been invited to take part by planning activities to thank nurses for their services in their own facilities. The purpose of the week's activities is to increase public understanding of the nurse's important role in health care, to recruit high schoolers to a future nursing career, and to salute the contribution of the state's nurses to the general welfare of its people.

HOT OFF THE PRESSES: LEGISLATIVE ISSUES GUIDE. Legislative issues of concern to Wisconsin physicians in recent legislative sessions as well as those which will undoubtedly be debated again in the 1983 session are contained in the "1983 Legislative Issues" booklet recently published by the Society's Physicians Alliance Division. The concise and comprehensive booklet is intended to serve as a resource to SMS members, candidates for public office, legislators, and concerned citizens. Physicians interested in receiving a copy should write the SMS Physicians Alliance office in Madison, PO Box 1109, Madison, WI 53701. ■

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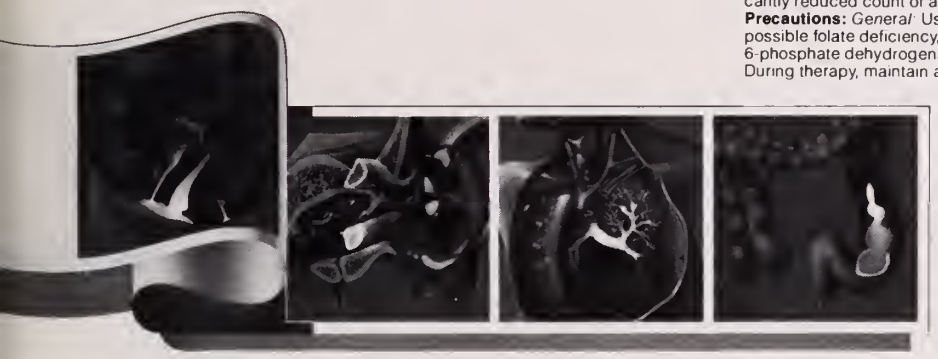

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Before prescribing, please consult complete product information, a summary of which follows:
Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* it is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. *Note.* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.
For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.
For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.
For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.
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Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.
Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted
Precautions: *General:* Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.
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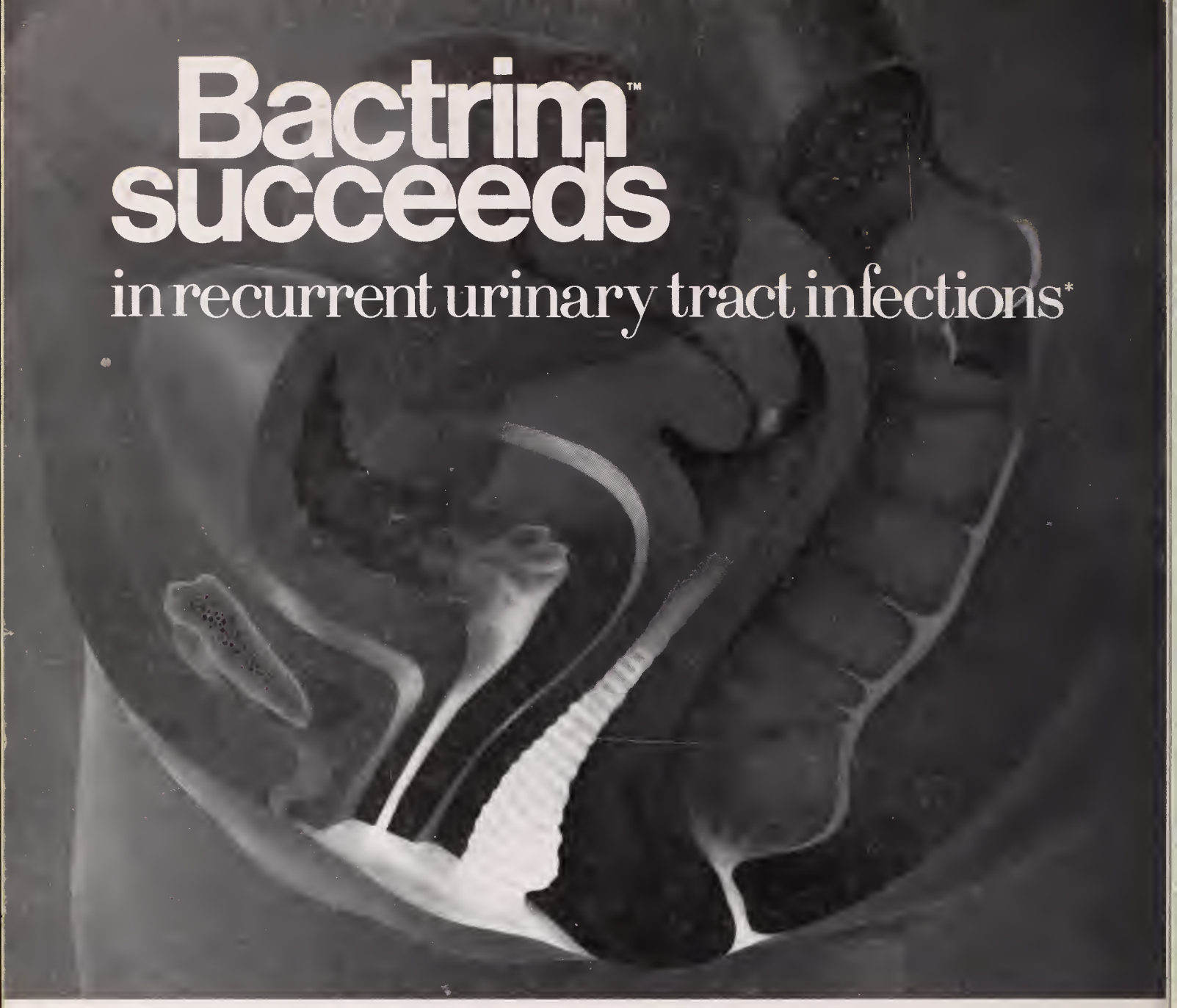

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OCTOBER 1982

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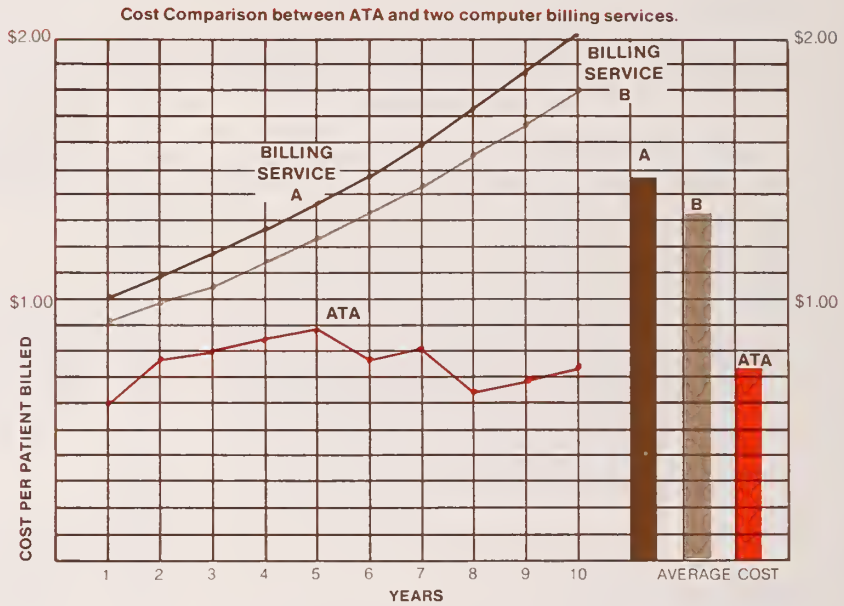

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President's Page

.....Gerald C Kempthorne, MD

A change of direction for organized medicine

A NATIONAL PARADOX exists in our society. There is a clamor from virtually all segments of our cost-conscious parties to do "something" about health care costs. Now that the House of Medicine is *truly* interested in participating in efforts to slow the acceleration of health care costs, the Federal Trade Commission indicates that it will continue to pursue any group which acts collectively to help solve the problem. The paradox is simply that the government and the people at large want action on the control of costs of health care—while the FTC, on the other hand, wants to restrain any sincere effort on our part to attempt to accomplish the same end. It is actually a case where the left hand doesn't know or care what the right hand is doing. It is a paradox which must cease. Organized medicine is in the "mood" to help restrain cost escalation in the profession and related health care fields. It took us a while to reach this state of awareness. How sad and ridiculous it is that we are now being discouraged by the federal government to do what the people want.

During the recent visit to Washington, DC, one of the congressional leaders clearly pointed out his concern about that huge portion of the economy being spent for health care. He emphasized the importance of the urgency of corrective action—requiring the active participation of the medical profession. It appears it may be necessary to provide advice to responsible parties even at the risk of being "indicted" by the Federal Trade Commission in order to provide our important influence on the scene of health care matters, in general.

Fragmentation of effort seems to exist in the long-range health care planning in this country. Government appears to function with the assumption that it is the logical body to design and plan for the future health of America. The American Medical Association is developing a model for a national health policy for America with the help of all involved parties. This stroke of proactive behavior with the endorsement of the House of Delegates seems to indicate a change of direction in organized medicine. Fortunately, the national organization is reacting less and planning more. Organized medicine still represents the voice of medicine, and it is timely that we choose to provide direction to the future planning of the delivery of health care.

Wisconsin needs the same kind of direction. It is awkward for government and organized medicine to "walk" separate roads to the ultimate goal of providing health care to our citizens. It is my conviction that it is crucial to continue to improve and build on the relationship between government and medicine. I have stated clearly that I consider organized medicine in Wisconsin to be a very important and influential force. It is obvious that government is deeply committed to the same ultimate purpose in addition to its role in financing a component of the system. Since both entities are involved by mandate and moral commitment to various degrees, why travel on both sides of the road when we must cross the bridge together? Differences of the past can and should be transcended. The future is upon us and time may be "running out" if solutions for positive direction cannot be developed and implemented.

The complexity of the huge health care delivery system in Wisconsin is such that a bold, long-range, and imaginative plan is clearly needed. Recently, I heard a physician describe a situation where Medicaid recipients were receiving costly immunizations from a private source—virtually next door to a *free* service provided by a local government. A grand plan is needed for the days ahead. Who could initiate such a planning project any better than the medical profession? Imagine how exciting it could be if the State Medical Society chose to embark on a project of trying to draw up a long-range plan for the health care of our patients? Naturally, it would be essential to involve the many participants in the whole process. Why should we wait for government or other organizations to tell us how and when to care for people? What other group of people has any greater expertise or desire to design such a grand plan as does the State Medical Society?

This is the propitious time for us to demonstrate our sincerity in developing a plan for the future with government as an important partner. ■

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See "WARNINGS"

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Editorials WAYNE J BOULANGER, MD, *Editorial Director*

Official positions of the Society will be expressly identified as such; all others are views of the writer and not necessarily those of the Society.

Solicitation

SEVERAL YEARS AGO an article was published in the *Wisconsin Medical Journal* describing a particular service that was available in Wisconsin's largest city. This generated some warm (caloric, not friendly) correspondence from two other medical centers. The correspondents strongly suggested that we were guilty of providing free advertising and inferred that equal time might be indicated.

At the last meeting of the Editorial Board the subject of solicitations and announcements was considered in depth. The Journal receives numerous announcements about the opening of new medical facilities, the addition of some sophisticated new equipment in a hospital, or the request for the referral of a specific type of patient. The last, most frequently from the National Institutes of Health where certain, usually rather rare, types of malignancies are sought for referral.

In this issue of the *Wisconsin Medical Journal* is a letter to the editor relative to the August issue which was devoted to geriatric medicine. Dr Steven Gambert, who was the guest editor of that special issue, is the chairman of the Committee on Aging and Extended Care Facilities of the State Medical Society of Wisconsin. Although all of the authors for that special issue are from Milwaukee, obviously the problem of caring for the aging is statewide, and Milwaukee is not trying to corner the market on caring for the aged.

It has been a long-standing policy of the *Wisconsin Medical Journal* to reject drug testimonials and not accept articles that are obviously self-serving or that could be construed as solicitation. This policy will be continued, but it is not possible to leave out names of authors along with their home towns and hospital affiliations.—VSF

Hepatitis B vaccine available

THE DIVISION OF HEALTH of the Wisconsin Department of Health and Social Services has announced that hepatitis B virus (HBV) vaccine is now available. It is marketed by Merck, Sharp & Dohme, and initial supplies are limited. The antigen in HBV vaccine is obtained from plasma of human carriers of HBV.

Three intramuscular doses of 1.0 ml of HBV vaccine have been shown to produce protective antibodies in more than 90 percent of healthy adults and to prevent hepatitis B infection among 80 to 95 percent of susceptible persons. Side effects from the vaccine have been limited to redness and soreness at the injection site. Vaccination of individuals who possess antibodies against HBV from a previous infection is not necessary but will not cause adverse effects, and HBV vaccine does not eradicate the HBV carrier state.

The second and third doses should be given one and six months after the first immunization. For children under ten years the dose is 0.5 ml at the same intervals, but for patients undergoing hemodialysis and other immunosuppressed patients, the dose is 2.0 ml again at the same intervals. Optimal protection is not conferred until after the third dose. The vaccine cost from the manufacturer is approximately $100.00 for the 3.0-ml vial.

Because of the limited supply of the vaccine, it should be used for those who are at an increased risk of HBV infection. These high-risk groups include immigrants and refugees from areas with high HBV rates, clients and staff of institutions for the mentally retarded, users of illicit injectable drugs, homosexually active males, regular household and sexual contacts of HBV carriers, hemodialysis patients, recipients of factor VIII or IX concentrates, male inmates at long-term correctional facilities, and selected health workers who have frequent contact with blood and blood products. Prescreening for anti-HBs among high-risk groups is recommended as a measure to improve the vaccine availability and as a cost-saving measure. In Wisconsin there are over 30 laboratories that test for anti-HBs.—VSF

"Big Red" gone

NEITHER WISCONSIN football nor Wisconsin medicine has ever had a more enthusiastic booster than Frank L Weston, MD of Madison. Long known as "Red" Weston, he made a name for himself on the 1920-21 University of Wisconsin football team.

Graduating from the UW in 1921 and from Rush Medical College, Chicago, in 1923, he returned in 1925 to Wisconsin where he quickly established himself as a "star" doctor with his patients and for the UW football team, a well-liked and much-respected teacher of medical students, and a wise and able leader in the State Medical Society.

Doctor Weston won the hearts of his comrades as commander of the 44th General Hospital Unit in the South Pacific in World War II. Shortly there-

after he was tapped by the State Medical Society and the Selective Service System for the difficult and mostly unrewarding task of directing the Wisconsin "doctor draft" during the Korean conflict. No one was ever able to say Doctor Weston wasn't scrupulously fair in choosing who would go and who would stay.

For many years he served as treasurer of the State Medical Society, another vital but often unsung role. Everyone was aware that the Society's finances were in good hands with Doctor Weston.

"Big Red" is gone. He passed away on September 1, 1982. He left, as he should have, to the silent yet ringing cheers of thousands—patients, doctors, football fans and players, friends—who knew his love and care. ■

Letters

The Editors would like to encourage physicians to contribute to the LETTERS section where they can ventilate their frustrations as well as opinions. This feature is intended to be lively and spirited as well as informative and educational. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address correspondence to: The Editor, Wisconsin Medical Journal, Box 1109, Madison, Wis 53701.

Geriatric medicine

TO THE EDITOR: I enjoyed the issue of August 1982 directed toward geriatric medicine. It would be appropriate as an addendum to this issue to stress that other centers besides Milwaukee in the State of Wisconsin are actively involved in the evaluation of the impaired elderly patient. The Marshfield Clinic has had an elderly evaluation center in the planning stage for 1½ years and has been seeing impaired elderly patients over the last six months with the approach of integrating the medical, social, nutritional and financial aspects of the patient's problem into a workable community plan of therapy. Recently, Marshfield has offered a thirteen part series on common issues in geriatrics and made this available to newspapers throughout the state. Topics included in this series are: Dementia and aging, sleep and aging, heart disease in the aging population, and discussions of visual, sexual, rheumatological, psychological aspects of aging. Additional topics included nutritional needs of the elderly and financing of medical care in the future. Information about this series can be obtained by writing to Mr Tom Swenson, Marshfield Clinic, 1000 N Oak St, Marshfield, Wisconsin 54449.

I wish to congratulate Doctor Gambert and his group in Milwaukee, but also wish to draw attention to the effort at the Marshfield Clinic in the area of the aging impaired individual, as I'm sure the needs of Wisconsin elderly will depend upon the availability of a number of centers around the state which are sensitive to the particular needs of the aging population.

Philip M Green, MD
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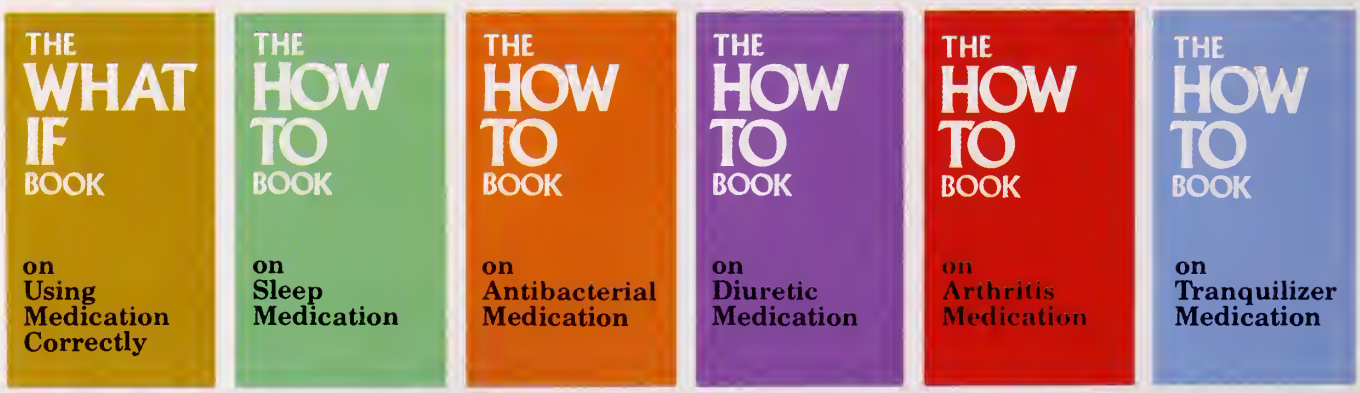

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Legal and practical aspects of interhospital patient transfers

Thomas A Reminga, MD, Milwaukee, Wisconsin

REPRESENTATIVES of the State Medical Society, along with the Wisconsin Hospital Association and the State Department of Health and Social Services, have recently investigated current Wisconsin practices and medicolegal responsibilities of transferring patients between hospitals.

Of specific concern was a recent article by DHSS informing all EMT-Basic ambulance providers that maintenance of intravenous lines during transportation was above their level of training and licensure and thus exposed to liability if a problem with the patient occurred in route. Further investigation leads to the conclusion that serious liability exists during a patient transfer not only for the ambulance personnel but also and most appropriately so for the transferring physician and hospital.

The central point is that when a patient is transferred from one hospital to another, the transferring physician and hospital are responsible for the patient's care until the patient is delivered to the accepting physician and hospital. If the patient's care is to be delegated to an additional health care professional during the transfer, it is his responsibility to carefully evaluate their capability, level of training, and licensure restrictions to make sure the patient's actual or reasonably foreseeable needs do not exceed their capabilities. As a group, registered nurses, EMT-Advanced (paramedics), EMT-Intermediates are capable by training of some, if not all, of the advanced life-support techniques including administration of drugs.

Those patients who are not critically ill, but have IV lines in place for reasons other than intermediate life-support can most effectively be handled by converting the IV line to a heparin lock for the transfer. As an additional solution, the State Medical Society's Commission on Health Planning has offered to encourage the development of an additional module for the EMT-Basic training course to instruct EMT-Basic providers on the techniques of maintaining basic IV lines and solutions. The Commission also is encouraging hospitals and municipalities to upgrade appropriate EMS systems to EMT-Intermediate provider status. ■

Doctor Reminga is the Emergency Medicine Representative of the Commission on Health Planning of the State Medical Society.

EMTs in Wisconsin

Ambulance Attendant License—Basic

Requires successful completion of the 81-hour US Department of Transportation, National Highway Traffic Safety Administration Basic Training Program for Emergency Medical Technicians. An examination prepared by the DHSS EMS Examining Council tests proficiency in both cognitive and practical skills. Trained in basic handling and transport techniques, ambulance attendants are prohibited by state law from either administering or monitoring injections and intravenous solutions.

Emergency Medical Technicians—Intermediate

Established by the state Legislature in 1981 to allow licensed ambulance attendants to be trained in and perform certain select skills beyond the basic life support level. The program is designed to be utilized in areas in which emergency medical technician—advanced (paramedic) status is impractical or unnecessary. An intermediate level EMT under the direction and supervision of a physician will be permitted to practice all of the following skills:

A) Utilization of an esophageal obturator airway or esophageal gastric tube airway, or both.
B) Administration of intravenous infusions.
C) Administration of subcutaneous injections.
D) Application of medical anti-shock trousers.
E) Drawing of blood samples.
F) Administration of selected medications.

Emergency Medical Technicians—Advanced (Paramedics)

Coordinated, directed and inspected by physicians, paramedics must complete at least 750 hours of training. Minimum paramedic equipment includes:

A) Sphygmomanometer (adult and infant size)
B) Stethoscope
C) ECG monitor with tape printout
D) Defibrillator
E) Intravenous setup
F) Intubation equipment as specified by the coordinating physician
G) Medications and drugs specified in their standard operating procedures and approved by the coordinating physician.

Either an additional paramedic or a physician must be present when acting in the "advanced" capacity. At all times, two way radio voice communication must be maintained between the ambulance, hospital and physician. ■

Special

The physician-observer . . .

Leonard Weistrop, MD, Shorewood, Wisconsin

I WILL BEGIN this view of the physician-observer with a look at Tolstoy's magnificent novel, *War and Peace.* The comparison of Napoleon to Kutuzov, the Russian general, is particularly instructive; Napoleon's character a metaphor for invasion while Kutuzov is the consummate observer.

First let us look at Napoleon standing in the middle of Moscow, a trophy left to him by the ponderous Kutuzov.

> *One word from me, one movement of my hand, and an ancient capital of the czars would perish. But my clemency is always ready to descend upon the vanquished. I must be magnanimous and truly great. . . but I shall spare her. On the ancient monuments of barbarism and despotism, I will inscribe great words of justice and mercy. . . I will give them just laws; I will teach them the meaning of true civilization. I will make generations of Boyars remember their conqueror with love.*

Napoleon is man-evolving, shaping the universe in his own image, bringing himself to everything and everyone. Exaggerated and special feelings are reserved for such a man: obedience, contempt, love, fear, suspicions, and worship; feelings well known to the physician.

Prince Andrew receives an interview with Kutuzov. He is disheartened about the course of the war. Andrew asks Kutuzov what can be done.

> *. . . but believe me, my dear boy, there is nothing stronger than these two: patience and time, they do it all. . . I will tell you what to do and what I do. When in doubt my dear fellow, do nothing.*

Andrew left the interview reassured especially about the man entrusted with the direction of the army.

> *The more he realized the absence of all personal motive in that old man in whom there seemed to remain only the habit of passions, and in place of an intellect (grouping events and drawing conclusions) only the capacity calmly to contemplate the course of events—the more reassured he was that everything would be as it should. He will not bring in any plan of his own. He will not devise or undertake anything, but he will hear everything, remember everything, and put everything in its place. He will not hinder anything useful nor allow anything harmful. He understands that there is something stronger and more important than his own will—the inevitable course of events, and he can see them and grasp their significance, and seeing that significance can refrain from meddling and renounce his personal wish directed to something else.*

Kutuzov does not tamper with the universe. He touches and is touched by events; that is all. Special feelings are reserved for such a man: love, isolation, bewilderment, and wholeness.

The seductive form and daily success of invasive medicine are familiar to us. Medicine is dependent on the penetrating and keen intellect of the invader; capable of imprinting man's hope upon life and dis-ease. Still the physician is never better than when he simply observes his patients; like Kutuzov, hearing everything, remembering everything, putting everything in its place.

Many of us will have difficulty remembering the last time we changed the course of nature. The dis-ease of our patients is always special; our intellect, or lack of it, is often separate from the course of illness. We might touch the patient, make an adjustment, relieve pain or at best ease the way of life or death. Strangely our best moments are times of listening, remembering, putting everything in its place.

Natasha of the venerable Rostov family becomes seriously ill after breaking off her engagement. Many consultants come to her: prescribing many medicines, speaking foreign languages and blaming each other.

> *But the simple idea never occurred to any of them that they could not know the disease Natasha was suffering from, as no disease suffered by a live man can be known, for every living person has his own pecularities and always has his own peculiar personal novel, complicated disease unknown to medicine— . . . not a disease of the lungs, liver, skin, heart, nerves, and so on mentioned in medical books, but a disease consisting of one of the innumerable combinations of the maladies of those organs. The simple thought could not occur to the doctors (as it cannot occur to the wizard that he is unable to work his charms) because the business of their lives was to cure, and they received money for it and had spent the best years of their*

Presented before the Doctor-Clergy Breakfast, Columbia Hospital, Milwaukee, January 6, 1982. Reprint requests to: Leonard Weistrop, MD, 2015 E Newport Ave, Milwaukee, Wis 53211 (phone: 414/961-2211). Copyright 1982 by the State Medical Society of Wisconsin.

lives on that business. . . but, above all, that thought was kept out of their minds by the fact that they saw they were really useful. . . their usefulness did not depend on making the patient swallow substances for the most part harmful, but they were useful, necessary, and indispensable because they satisfied a mental need of the invalid and of those who loved her and that is why there are, and always will be pseudo-healers, wise women, homeopaths, and allopaths. They satisfy the eternal need for hope of relief, for sympathy, and that something should be done which was felt by those who are suffering.

There is no changing the universe though it is man's particular nature and genius to try. The mass of technology assisting us, at times even directing us, seems to brighten our outlook, yet we feel worse and die, still with the same regularity as our ancestors. The pace of change, offered by this scintillating technology, occurs with a speed and regularity unknown until the past 100 years; creating, for the first time, an atmosphere wherein the life-experience of the father-mother is separate from the son-daughter, a guarantor of isolation and failing health.

Tolstoy is a great storyteller. There are no messages from him, the story is the message. His stories seem to boil over with unspectacular watching. Tolstoy is an exhaustive observer; he refrains from moralizing, hyperbole, or self-indulgence. Instead, he describes what he sees, nothing else. We look into Tolstoy's mirror and see ourselves instead of Tolstoy, a writer or physician, could do no better.

The physician-observer, like Tolstoy, is moral, not moralizing. He withholds sympathy—a measure of inequality. Empathy is his method; he will stand in the patient's shoes, feel his pain, even taste it; but he will soon enough step out of the patient's shoes and avoid swallowing what he tastes—the patient, equal to the physician, is responsible.

The issue of responsibility is a central one for modern medicine. It is widely thought that the physician is the key ingredient in health; we need to discourage this view—it is the patient. The yearly exam (the full exam) is happily in its descendancy. The promise of recognizing and treating disease early has been, in the main, unrealized. Some of the participants in this system, eager to prevent disease, still smoking and swelling, maintain a justifiably tenuous view of their health, requiring yearly recertification in the fashion of cars. Others, successful in their attempts at prevention, still feel unwell as they constantly prepare for their yearly re-certification. We would help by attending to the sick and pained; leaving the well to earn, learn, and yearn—understanding Montaigne's simple view that man does not die of illness, but of being alive.

Many of us, near to coronary artery occlusion or ruptured appendix, would be somewhat chilled by the appearance of the physician-observer at the bedside. The Napoleonic image would seem more suitable to the occasion—a correct view, I believe. Medicine is obliged to those with sufficient courage and intellect to see the world, the universe, in new ways—challenging the conventional, promising the future. Still, we are wholly dependent on the physician-observer who hears everything, remembers everything, and puts everything in its place; the Kutuzov who will not hinder anything useful nor allow anything harmful; always mindful of the Greek master's admonition to do no harm. ■

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Acute perforation of gastric carcinoma

Theresa A Siegert, MD and **William L Donegan, MD,** Milwaukee, Wisconsin

ABSTRACT. *Eight cases of acutely perforated gastric carcinoma were collected from three Milwaukee hospitals. The incidence of this complication was 2.3% among 300 adenocarcinomas of the stomach. Patients typically presented with acute abdominal pain and signs of peritonitis. Free intraperitoneal air was a consistent finding on roentgenograms. Perforation through the carcinoma most commonly occurred anteriorly along the lesser curvature in the prepyloric area. The longest survival (18 months) followed initial oversew of the perforation and delayed gastrectomy. Immediate or delayed gastrectomy is the preferred treatment when feasible.*

ALTHOUGH MORTALITY from cancer of the stomach in the United States is declining, one cancer death in 30 is due to this tumor.[1] Its insidious onset and delayed symptoms continue to frustrate early detection with the result that fewer than 10% of all patients survive for five years after diagnosis. Acute perforation into the free peritoneal cavity is an infrequent complication of gastric carcinoma but one which requires accurate diagnosis and proper management in difficult circumstances.

The literature on this subject is meager. The authors were able to find reference to 159 cases of acutely perforated gastric carcinoma since 1951. Details were known in 42 of these cases, and not all had complete follow-up. The following is a report of eight cases with a review of management.

MATERIALS. In the tumor registries of three Milwaukee hospitals; *ie,* the Wood Veterans Administration Hospital, the Milwaukee County Medical Center, and the Columbia Hospital, eight cases were found of acutely perforated gastric carcinoma. Five of the eight cases were diagnosed histologically at surgery and two at autopsy; one was substantiated only by radiography and gastric cytology.

CASE REPORTS. *Case 1:* A 75-year-old male with chronic schizophrenia was admitted with fever, hypotension, and severe abdominal pain which began the day of admission. An abdominal examination revealed slight guarding and the presence of bowel sounds. The patient was treated for sepsis but did not respond well. On the second hospital day bowel sounds disappeared, left abdominal tenderness was noted, and an abdominal roentgenogram showed free peritoneal air. A laparotomy was performed immediately at which time much free bile and pus was found throughout the abdominal cavity. A 1.5-cm perforation was found anteriorly on the lesser curvature of the stomach, 4 cm from the esophagogastric junction. A biopsy of the edge of the ulcer was taken; it revealed diffusely-infiltrating, poorly-differentiated adenocarcinoma, and the perforation was oversewn. Postoperatively the patient's condition deteriorated and he died six weeks later. An autopsy revealed adenocarcinoma confined to the stomach, generalized peritonitis, and a subdiaphragmatic abscess.

Case 2: This 89-year-old male was originally admitted to a coronary care unit with pain suggestive of myocardial infarction. Cardiac findings were unremarkable but he had a tender and distended abdomen. A roentgenogram of the chest revealed free air under both diaphragms, and the patient was immediately operated upon with a diagnosis of perforated viscus. Extensive peritonitis was found with approximately a liter of purulent fluid. A perforation was present on the anterior wall of the distal stomach with a firm mass beneath the perforation. A distal gastrectomy (50%-60%) with gastroduodenostomy was carried out. The surgical specimen contained an infiltrating, poorly-to-moderately differentiated, nonmucin-secreting adenocarcinoma with extensive inflammation and ulceration. In focal areas the tumor involved the full thickness of the gastric wall; tumor also extended to the distal margin of the specimen. The patient was discharged to a nursing home four weeks after surgery and died 12 days later.

Case 3: This patient was a 58-year-old male, with a history of chronic alcoholism, who had been discharged from the hospital five days previously after treatment for bleeding esophageal varices. He returned with sudden, severe, generalized abdominal pain radiating to both shoulders. His abdomen was distended and diffusely tender, and a radiograph showed free air in the abdomen. An immediate celiotomy revealed a perforation of the stomach on the

From the Department of Surgery, Medical College of Wisconsin, Milwaukee. Doctor Siegert is a first-year resident in surgery; Doctor Donegan is Professor of Surgery and American Cancer Society Professor of Clinical Oncology. Publication support provided. Reprint requests to: William L Donegan, MD, Dept of Surgery, Box 145, Medical College of Wisconsin, 8700 West Wisconsin Ave, Milwaukee, Wis 53226 (phone: 414/257-5226). Copyright 1982 by the State Medical Society of Wisconsin.

lesser curvature near the esophagogastric junction in an area of marked induration. Biopsies proved the lesion to be an adenocarcinoma. The perforation was oversewn. Ten days later a total gastrectomy, splenectomy, and distal pancreatectomy was carried out with an esophagojejunostomy reconstruction. The surgical specimen contained an ulcerating, moderately well-differentiated adenocarcinoma extending through the serosal surfaces with metastases to 2 of 14 regional lymph nodes. The patient had a complicated postoperative course and died five months later of respiratory failure. At the post-mortem examination metastatic cancer was present at the esophagojejunal anastomosis.

Case 4: This 58-year-old man, who had been treated four months earlier for a Dukes A adenocarcinoma of the sigmoid colon, entered the hospital with weight loss, dysphagia, occasional vomiting, and abdominal pain. Gastroscopy revealed a friable tumor, which extended from the stomach up to the middle third of the esophagus; it was considered too extensive for surgical resection. Gastric washings showed adenocarcinoma but a biopsy could not be obtained due to bleeding. He received radiation therapy followed by chemotherapy with fluorouracil and was well except for progressive weight loss until two weeks prior to his final admission when he noted increasing weakness and nausea. Two days before admission he developed severe, progressive high abdominal pain and back pain not relieved by oral analgesics. On examination the abdomen was rigid with tenderness throughout, and roentgenograms of the abdomen demonstrated free air under the diaphragm. It was felt that the patient was terminally ill and treatment was limited to morphine for pain relief. He died on the second hospital day; no post-mortem examination was obtained.

Case 5: A three-week history of intermittent hiccups, weakness, regurgitation of food, substernal pain, and weight loss led to the admission of this 83-year-old man. He had been seen three months earlier because of complaints referrable to the stomach, and at that time an upper gastrointestinal x-ray series showed a large fungating lesion involving most of his stomach. A gastroscopy on this occasion was consistent with carcinoma, and he was told the nature of his problem, but he chose to ignore it. Eight days after admission he developed severe, right lower quadrant abdominal pain, and radiographs showed free peritoneal air. No operation was performed. The patient died three days later; at autopsy 800 ml of clear, straw-colored fluid was found within the peritoneal cavity. A large rock-hard tumor mass, which had perforated anteriorly, occupied the pylorus. The stomach wall contained a carcinoma with large areas of coagulation necrosis. Metastases were found in the liver and regional lymph nodes.

Case 6: Increasing abdominal pain of 24 hours duration caused this 86-year-old woman's admission. Two years previously she had been evaluated for two superficial gastric erosions along the posterior wall in the area of the angularis. At that time gastric cytology was atypical; gastric acids were normal. The patient declined further investigations, but within a month she required an operation to close a freely perforated gastric ulcer on the anterior wall just proximal to the pylorus. On the present admission a tender mass could be felt in the epigastrium, and gastric cytology revealed tumor cells. No lesion was seen at gastroscopy, but an upper gastrointestinal x-ray series was consistent with carcinoma. At surgery a large mass was found in the posterior wall of the stomach along the lesser curvature secondary to a large perforated ulcer which had eroded into the pancreas. A subtotal gastrectomy with Billroth I anastomosis was performed. Sections through the ulcer revealed an infiltrating, poorly-differentiated adenocarcinoma extending to the serosal surface. The patient was discharged eight days after her operation. However, she returned six months later with increasing weakness, abdominal pain, and an abdominal mass. She died of carcinomatosis six weeks later.

Case 7: This 67-year-old male presented after two months of nausea, vomiting, abdominal pain, and weight loss. Roentgenograms revealed a constricting lesion of the mid stomach which permitted only a thin stream of barium to pass. At laparotomy the stomach was involved by an extensive tumor which had constricted the junction of the middle and upper thirds of the stomach to an hour glass deformity. There were many peritoneal metastatic nodules and hepatic metastases. The patient developed cardiorespiratory difficulties postoperatively and died six days after the operation. An autopsy revealed acute peritonitis due to perforation of the neoplasm through its central portion along the greater curvature. Approximately 500 ml of light brown, foul smelling, opaque fluid was present within the peritoneal cavity. The neoplasm was a well-differentiated adenocarcinoma which had infiltrated completely through the gastric wall.

Case 8: For two weeks this 65-year-old male had experienced intermittent, severe upper abdominal pain not relieved by food. Five days prior to admission he vomited blood several times and his stools turned grey. A sudden increase in pain 18 hours before admission forced him to seek medical help. On examination his abdomen was exquisitely tender in the epigastrium with some guarding. A chest x-ray and an abdominal x-ray showed free air under the left hemidiaphragm. The patient was operated upon with a diagnosis of perforated viscus. A 3-mm perforation was found on the anterior surface of the distal stomach near the lesser curvature. In this region an 8-cm mass involved both the anterior and posterior walls. Underlying the serosa on the greater curvature were several firm grey nodules. The area of perforation was closed and covered with a pedicle of omentum. The patient recovered without difficulty, and two and one-half

FIGURE 1—*The gastrectomy specimen from Case 8 has been opened along the greater curvature to reveal a large ulcerated cancer with rolled edges. It occupies the entire lesser curvature as well as most of the anterior and posterior walls of the stomach. Sutures can be seen traversing the lesser curvature in the center of the cancer where the perforation was closed two and one-half weeks earlier (arrows).*

weeks later a 90% gastrectomy, omentectomy, and gastrojejunostomy was performed (Fig 1). At this time tumor involved all layers of the stomach, was firmly adherent to the transverse mesocolon, and extended to the region of the celiac axis. Metastases were also present in the superior gastric nodes. The patient died 18 months following this operation.

DISCUSSION. The frequency of gastric perforation due to carcinoma does not appear to have changed appreciably from earlier reports. Seven of our cases were seen between 1969 and 1979, a period during which 300 cases of adenocarcinoma of the stomach were diagnosed. This incidence (2.3%) is similar to that reported by Guiss (3.7%) prior to 1951.[2] More recently, Olearchyk found 2.9% among 243 cases of gastric carcinoma, and Ekbom and Gleysteen reported 1.3% among 144 cases.[3,4]

Our patients' average age of 73 years is considerably higher than the 59 years reported by Larmi in 1962 and the 64 years reported by Wilson in 1966, but the numbers are few.[5,6] The predominance of males (7/8) can be attributed to the higher incidence of gastric carcinoma in males (1.5 × the frequency in females) and the inclusion of a Veterans Administration Hospital in our patient pool.

Typically, the patients presented with acute abdominal pain and signs of peritonitis. Free peritoneal air was documented with roentgenograms of the abdomen in 86 percent (6/7) of the cases. The eighth case perforated twice. No roentgenogram was made at the initial episode although much free air was noted by the surgeon on entering the abdomen. The second perforation was localized so none would be expected.

Although 8% of acute gastric perforations and 3% of all gastroduodenal perforations are due to cancer, the diagnosis is not often suspected preoperatively.[5] The presence of cancer was known in three of our cases; but when this information was lacking, clues to the true cause of the perforation were few. McNealy and Hedin suggested that middle or advanced age, a history of weight loss, lack of free gastric acid, and gross or occult blood in the stool favored carcinoma rather than benign ulcer.[7] In fewer than half of our cases were suggestive symptoms recorded. Only two of the five without known cancer had premonitory gastric distress; one reported hematemesis, and in none was weight loss recorded. One of the patients had a palpable epigastric mass but none had supraclavicular adenopathy. Two of the eight gave a misleading history of prior ulcer disease. It is of interest that one of these patients had a history of multiple gastric erosions and perforated on two occasions. A biopsy of the ulcer at the time of the first perforation may have led to an earlier diagnosis. Larmi stated that malodorous, anaerobically infected fluid in the abdominal cavity supported a diagnosis of carcinoma.[5] In only one case in our review was foul abdominal fluid described.

Table 1—*Summary of treatment and results*

CASE	SEX	AGE (YRS)	LOCATION OF PERFORATION	TREATMENT	SURVIVAL AFTER PERFORATION
1	M	75	Anterior, on proximal lesser curvature	Oversew	6 weeks
2	M	89	Anterior, distal stomach	Distal 60% gastrectomy & Billroth I	6 weeks
3	M	58	Anterior, on proximal lesser curvature	Oversew, with delayed total gastrectomy	5 months
4	M	58	Unknown	None	2 days
5	M	83	Anterior, pylorus	None	3 days
6	F	86	Posterior, on mid lesser curvature	50% gastrectomy and Billroth I	7.5 months
7	M	67	Posterior, on mid greater curvature	None	<6 days
8	M	65	Anterior, on distal lesser curvature	Oversew, with delayed 90% gastrectomy and Billroth II	18 months

The most frequent site of perforation is the distal anterior wall of the stomach on or near the lesser curvature, the site at which most gastric adenocarcinomas arise.[7,8] All but two of our cases perforated anteriorly and four of the eight were near the lesser curvature, usually in the distal stomach (Table 1).

Perforations occurred directly through the tumors rather than proximally or at other sites in the stomach apparently from focal necrosis of deep neoplastic ulcerations (Fig 1). Therefore, perforations are generally indicative of large primaries and advanced stages of disease. It was possible to document that the primary tumor extended completely through the gastric wall in six of our patients. Metastatic disease either to lymph nodes (3 patients), the liver (2 patients), or the peritoneum (2 patients) was found in four (57%) of our seven patients that had an exploration or an autopsy. In an additional patient the pancreas was invaded directly. Koshal and Naik suggested that gastric distention contributed to perforation of gastric cancers in some cases, but we were unable to document this.[9]

The advanced stages of perforated gastric cancers signal a poor prognosis; survival for only a few months is the rule. We were able to find no cures in the literature, although extended survivals were reported. Heimlich reported a seven-year survivor and referred to a patient, described by Emmett, who lived six years after gastric resection. Both patients died of recurrence.[10,11] A patient described by Wilson lived 41 months after closure of the perforation and secondary gastrectomy before succumbing to recurrence.[6] Our longest survivor lived for 18 months (Table 1). Nonsurgical treatment regularly led to death within days from peritonitis and sepsis. The severity of the immediate problem is well illustrated by the fact that two (40%) of the five patients operated upon failed to recover from the acute episode. Even this high figure possibly reflects advances in supportive care, as immediate surgical mortalities of 54% to 59% were reported before 1938.[7,8] Since 1946 mortality has ranged from 30% to 50%.[5,6]

Most reports conclude that immediate gastrectomy is the treatment of choice if the patient's condition permits.[5,6,8,10,12] Gastrectomy expeditiously controls contamination, obviates a second operation to remove the cancer, and can be performed with an acceptable risk. In selected cases the mortality reported for gastrectomy in these circumstances has been as low as 13% to 25%.[2,12] If gastrectomy is not feasible, biopsy of the margin of the perforation for diagnosis, closure, and patching with omentum followed by gastric resection at a second stage is a suitable alternative. Our two patients in whom the perforation was oversewn and gastrectomy performed at a later date survived even longer than did the two patients who had immediate gastrectomy; thus, if the patient survives the initial insult, the ultimate result seems to be influenced primarily by the extent of the cancer rather than temporary delay of the resection. Whether resection is undertaken immediately or is delayed, the objective should be total removal of the cancer. In one of our patients (Case 2), surgical margins on the stomach were not free of cancer, obviously precluding any prospect for successful treatment.

While the experience has been that gastrectomy rarely cures perforated gastric carcinoma, a complete resection is often feasible and does keep open this possibility. In the absence of cure, gastrectomy still offers the possibility of protracted survival and provides worthwhile palliation by preventing bleeding, obstruction, and reperforation.

SUMMARY. Eight patients with acutely perforated adenocarcinoma of the stomach are reported. The patients characteristically experienced sudden abdominal pain and had physical signs consistent with acute

peritonitis; almost all had free intraperitoneal air on roentgenograms. Most perforations due to cancer occur anteriorly along the lesser curvature in the prepyloric area. Gastric perforations should be biopsied routinely in order to detect the presence of malignancy and to guide treatment. Immediate gastrectomy, if the patient's condition permits, or closure of the perforation with delayed gastrectomy are preferred treatments. Although no patient was cured, gastrectomy provided palliation and was associated with worthwhile survival.

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Abstracts

The following abstracts are from papers presented at the Wisconsin Neurological Society meeting, May 16-17, 1981, in Green Bay, Wisconsin. Gastone G Celesia, MD of Madison, who is Secretary for Medical Education of the WNS, served as coordinating editor for these abstracts.

The behavioral conceptualization and treatment of parkinsonian symptoms

George K Montgomery, PhD; Charles S Cleeland, PhD
Madison, Wisconsin

The initial optimism surrounding the treatment of Parkinson's disease with L-Dopa has waned in recent years as the dosage-related effects of long-term treatment have become clear. Many neurologists advocate withholding L-Dopa as long as possible, or minimizing the dosage, so as to prolong its benefits, encouraging patients to tolerate a modest expression of symptoms. A behavioral analysis of Parkinson's disease reveals that symptoms are commonly aggravated by work-or-emotional stress, and by fatigue. Three case studies examine the benefits of behavioral treatment procedures which have been demonstrated effective in the management of other neuromuscular disorders and emotional disturbances: (1) progressive relaxation training, (2) electromyographic (EMG) biofeedback training for improved neuromuscular control at rest and under relevant behavioral challenges, and (3) stress management training emphasizing cognitive-behavioral procedures. The results suggest that a multimodal behavioral treatment may assist pharmacological treatment in the management of parkinsonian symptoms, particularly in patients who are not exhibiting an unstable response to medication. ■

The borderlands of epilepsy revisited: I. Pseudoseizures

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Seventy-five years ago Sir William Gowers published his work *The Borderlands of Epilepsy,* as a sequel to his work *Epilepsy and Allied Disorders.* The many developments in diagnosis and therapy since 1907 render a review of the borderlands fruitful. Some 50 patients in this borderland area (predominantly from the Madison VA Hospital) were studied in the various categories of the borderlands.

This first presentation dealt with the problem of pseudoseizures. Contrary to many often held opinions, pseudoseizures, or hysterical seizures, are not sex or age linked and may occur at any age and in either sex. They are characterized by the atypical nature of the seizure, the absence of ictal, autonomic and of postical phenomena and the absence of epileptogenic changes in the electroencephalogram. The induction of, or the halting of, a seizure by suggestion greatly strengthens the diagnosis. But in addition to this there must be some reason for the occurrence of pseudoseizures. The patient's personality structure is important as is the effect of the seizure, for example, manipulation of the environment. ■

Cystic adventitial degeneration of the popliteal artery

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ABSTRACT. *A case of cystic adventitial degeneration of the popliteal artery is reported. The patient was a 37-year-old male with a one-year history of progressive right lower leg claudication. Physical examination disclosed absent distal right leg pulses, and an arteriogram revealed a discrete filling defect in the popliteal artery. This segment was surgically excised and found to contain multiple mucous cysts in the adventitia. The relevant literature is reviewed.*

ARTERIAL ADVENTITIAL CYSTIC degeneration is an uncommon phenomenon only occasionally documented in the general medical literature.[1-6] This disease characteristically affects the popliteal artery of males in the fourth or fifth decade, often presenting with claudication. Cases involving vessels other than the popliteal—the femoral, iliac, radial, and ulnar arteries, for example—have been reported rarely.[3,6] In a recent worldwide review of 105 cases only 13 had been reported from North America.[1] We recently encountered a patient with typical features of this disease.

CASE REPORT. A 37-year-old white factory worker was admitted to the hospital with a one-year history of increasingly severe exertional right leg claudication. The patient had been entirely well prior to onset of this problem. There was no history of trauma, cardiovascular disease, or diabetes mellitus. A ten-pack per year cigarette smoking history was obtained.

Physical examination was remarkable for lack of right popliteal, posterior tibial, and dorsalis pedis pulses. Electrocardiographic studies and chest x-ray films were unremarkable. Routine hematologic and chemical studies were also within normal limits.

An arteriogram of the right leg (Fig 1) revealed a discrete triangular filling defect in the mid-portion of the popliteal artery. The superficial femoral artery, the popliteal artery proximal to the lesion, and the arteries distal to the lesion were normal.

At surgery a limited area of adventitial fibrosis was found in the region of the stenotic popliteal artery. Two and one-half centimeters of the artery were excised and a saphenous vein graft inserted with subsequent return of full pulses to the distal leg and foot.

Pathology. Two portions of artery were submitted. The lumina appeared intrinsically intact. However, multiple cystic spaces up to 0.7 cm in maximum diameter were present in adventitia (Fig 2). These cysts were filled with copious amounts of clear viscid mucus.

Microscopic examination revealed portions of arterial wall in which numerous irregularly shaped and variably sized cystic spaces were present in the

FIGURE 1—*Angiogram of popliteal artery demonstrating the triangular shaped filling defect in the vessel mid-portion (center).*

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FIGURE 2—*Portion of resected popliteal artery with multiple mucous-filled cysts (middle and bottom) beneath the luminal surface (top).*

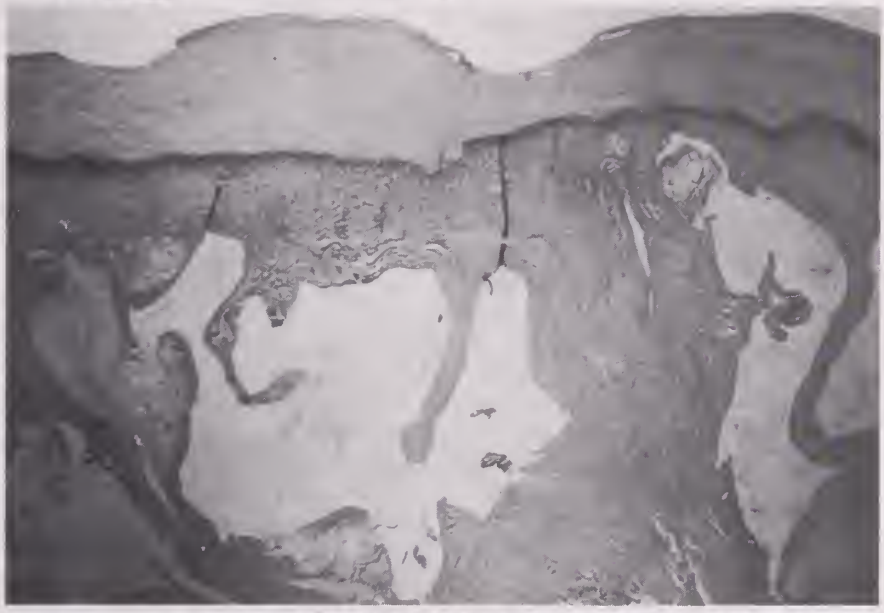

FIGURE 3—*Multiple adventitial mucous cysts (middle and bottom) clearly separated from media and intima by the darkly staining external elastica (H&E, original x31).*

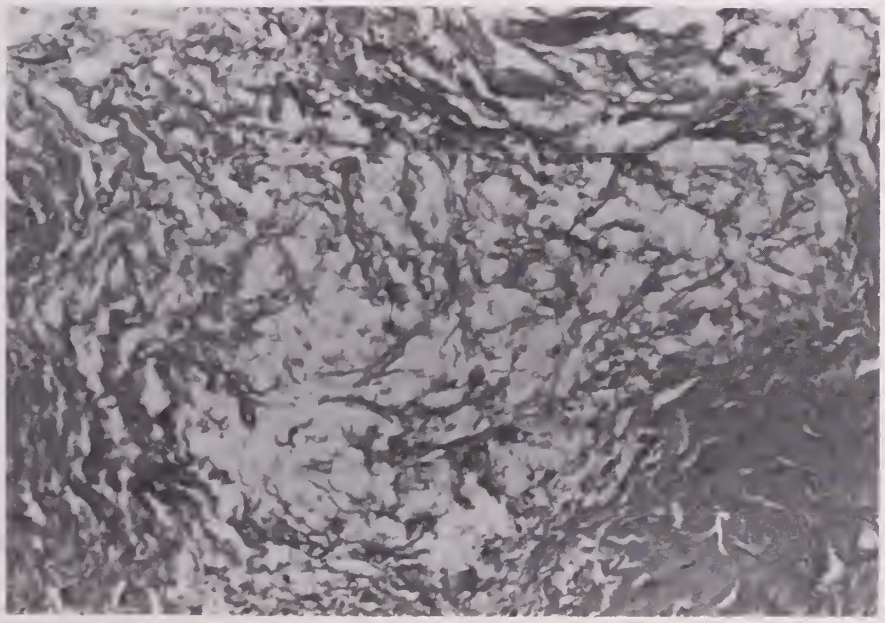

FIGURE 4—*Area of probable incipient cyst formation. Note resemblance to developing cystic ganglion (H&E, original x312).*

perivascular adventitia (Fig 3). Much of the grossly appreciated mucus appeared to have been lost or dissolved during routine processing.

These cysts were surrounded by relatively hypocellular hyalinized fibrous tissue and were lined predominantly by flattened cells with ovoid to polygonal bland appearing nuclei, inapparent nucleoli, and moderate amounts of slightly bubbly eosinophilic cytoplasm. While generally a single layer in thickness occasional foci of apparent stratification were also seen. Elsewhere no lining whatsoever could be identified. Portions of some well-formed cysts and in areas of apparent insipient cyst formation the adventitial tissues had a loose, edematous, slightly myxoid appearance (Fig 4). Some cysts had finger-like fibrous septa projecting into their lumina.

All cysts were confined to perivascular adventitial tissues. Occasionally, a cyst extended toward the external elastica but was never seen to cause full thickness disruption of the elastic or to involve the media. The external elastica itself displayed no consistent change, sometimes appearing normal, sometimes thinned, and sometimes thickened with some fragmentation. The media of the artery was somewhat hypocellular on routine hematoxylin and eosin sections; with trichrome stains, mild fibrosis was evident. The internal elastica displayed only a few scattered areas of fragmentation and reduplication. The intima had undergone focal mild fibrous thickening.

DISCUSSION. Although the typical individual with cystic adventitial degeneration of the popliteal artery is a healthy male in his fourth or fifth decade of life, there are reports of this disease occurring in nearly all age groups and occasionally affecting females.[1,3,4] Patients usually present with sudden onset of unilateral lower leg cramping and progressive claudication. Signs of ischemia such as decreased or absent distal pulses may be seen, although sometimes only after exertion.[1,3] Arteriography usually reveals smooth-walled stenosis or occlusion of the popliteal artery but an otherwise normal arterial tree. A variety of resection and nonresection techniques have been applied, success apparently depending in large part on the individual clinical setting.[1,4,5] The histopathology in the present report is typical of these lesions.

A variety of theories have been proffered concerning the etiology of these adventitial cysts.[1-5] They have been ascribed to trauma, to the secretory activity of displaced mucous-secreting cells from the joint space, to local manifestations of a generalized connective tissue disorder, and to true ganglia derived from tendon or joint capsule. We would only comment that the histologic changes in our case and most of those in the literature are strikingly similar to those seen in typical developing and well-formed cystic ganglia.

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Abstracts

Bilateral pheochromocytoma and islet cell adenoma of the pancreas

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An 18-year-old woman with bilateral pheochromocytomas and an asymptomatic islet cell adenoma of the pancreas represents the 11th patient to be described with this combination of endocrine tumors. No other components of any multiple endocrine adenomatosis (MEA) syndromes were present. Because of this "overlap syndrome," in which tumors that have traditionally been considered to be components of separate and mutually exclusive MEA syndromes have occurred concomitantly in the same patient, a question is raised regarding the validity of a rigid classification of these various MEA syndromes. The possibility of a pancreatic tumor should be kept in mind in any patient with a pheochromocytoma, especially if it is bilateral or multicentric in origin. ■

Laxative overdose in a 16-year-old female

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ABSTRACT. *A 16-year-old female developed explosive diarrhea, abdominal cramps, and marked hypokalemia following the ingestion of 39 Correctol tablets. Early treatment with intravenous fluids and intravenous potassium was important to the resolution of her problem. Despite the fact that she had taken a less than "lethal" dose of the laxative, the symptoms were striking and the illness severe. High levels of awareness should be maintained when individuals take similar doses of laxatives of this type, and intervention should be undertaken quickly.*

NUMEROUS OVER-THE-COUNTER laxative remedies are available. Most of these are benign when taken in prescribed doses. However, most can produce severe gastrointestinal illness if taken in quantities larger than recommended. Phenolphthalein and dioctyl sodium succinate are commonly available over-the-counter. When abused, there can result medical emergencies such as acute colitis, significant hypokalemia due to fluid outpouring, and abdominal pain mimicking acute surgical abdomen.

The purpose of this presentation is to underscore the potentially harmful nature of such compounds. A secondary point of discussion involves the awareness that the medications of this type may be taken by patients with anorexia nervosa or by those individuals extremely concerned about their weight and appearance. These compounds may be taken to achieve a quick weight loss.

CASE REPORT. A sixteen-year-old female came to the hospital emergency room complaining of severe lower abdominal cramps and explosive diarrhea. She stated that she had been quite constipated and had then taken 39 Correctol tablets in order to relieve herself. However, further history taking from her parents and friends disclosed that she had become extremely concerned about gaining too much weight. She constantly asked her friends if she appeared to be "too fat." Further inquiries revealed that she frequently gagged herself to induce vomiting in hopes of losing weight, and a search of her room produced several Fleet enemas. There was no preexisting history of any psychological disturbance. Her previous health was described as excellent, and her parents stated that she usually ate with good appetite.

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Physical examination on admission revealed an anxious 16-year-old female having extreme abdominal distress. She was unable to lie quietly because of severe abdominal cramping. Blood pressure was 96/50 mm Hg; pulse rate was 108 per minute; respirations were 22 per minute. Examination disclosed slightly dry mucous membranes consistent with early dehydration. The abdomen was held in a rigid position. Palpation of all four quadrants showed rebound and guarding. Bowel sounds were hypoactive. Rectal examination revealed normal sphincter tone with scant, but guaiac positive stool.

Laboratory data revealed the white blood count to be 17,000 shifted to the left with 88 segmented cells and six bands. Hemoglobin was 16.6 gm indicating hemoconcentration. Urine specific gravity was 1.032. Electrolytes were abnormal with potassium of 2.7 mEq/liter. Serum amylase and lipase were normal. Chest x-ray film and flat and upright abdominal films did not reveal free air or sign of perforation. No other abnormalities were present.

The patient was admitted and immediately assessed by a surgeon. She did not appear to have an acute surgical abdomen, and was placed in intravenous supplementation and intravenous potassium. Fiberoptic sigmoidoscopy disclosed the terminal 50 cm of colon to be grossly erythematous, friable, and severely imflamed. No biopsies were taken due to the extreme inflammation. Findings were suggestive of an acute colitis.

The patient continued to have explosive bowel movements for the first 12 hours following admission. She gradually became more comfortable and was able to tolerate oral fluids. Following 24 hours of intravenous fluid administration with potassium supplementation, her mucous membranes became normal and her potassium improved to 3.4 mEq/liter. Her white blood cell count was 12,200 per cu mm, and her abdomen became soft and flat, without any sign of rigidity. She continued to improve and was discharged on the third hospital day.

DISCUSSION: This patient probably does not represent true anorexia nervosa. She was only interested in maintaining her body weight at a "desirable" level. However, after a gain of five pounds, and feeling that she had to maintain her trim figure, she had decided to lose weight by the induction of vomiting. This method

had proved to be undesirable and did not achieve the hoped-for results. She then resorted to the use of laxatives, and took the large quantity of Correctol in order to "lose the weight fast." This young woman is described by her parents and peers as a "superachiever." She is an honor student and involved in many student activities. Among those activities is cheerleading; and when the weight gain occurred and she no longer looked the same in her cheerleading costume, she felt pressured to lose weight immediately.

Correctol (64.8 mg phenolphthalein and 100 mg dioctyl sodium sulfosuccinate) is a common over-the-counter laxative. It has been reported that certain individuals have taken as much as 8000 mg without permanent harmful sequelae. However, the ingestion of 39 tablets (2500 mg phenolphthalein equivalent) produced symptoms of acute colitis and resulted in the passage of explosive bloody stools and significant hypokalemia.

It remains to be seen whether this patient will need psychotherapy for her supposed weight problem. There are undoubtedly many such young people with similar social pressures and expectations. Physicians encountering such individuals should be alert for abuses of this sort; they also should be aware that even over-the-counter laxative preparations are capable of producing serious and potentially life-threatening situations. ■

Abstracts

"Milwaukee shoulder"—association of microspheroids containing hydroxyapatite crystals, active collagenase, and neutral protease with rotator cuff defects

I. Clinical Aspects

Daniel J McCarty, MD; Paul B Halverson, MD; Guillermo F Carrera, MD; Bruce J Brewer, MD; Franklin Kozin, MD

II. Synovial fluid studies

Paul B Halverson, MD; Herman S Cheung, PhD; Daniel J McCarty, MD; John Garancis, MD; Neil Mandel, PhD

III. Morphologic and biochemical studies of an excised synovium showing chondromatosis

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Medical College of Wisconsin, Milwaukee, Wis: *Arthritis and Rheumatism* 24:464-491 (Mar) 1981

Four women, aged 63 to 90 years, presented with mildly painful shoulders of decreased mobility or stability. X-ray evidence of a complete tear of the fibrous rotator cuff was present in seven of eight shoulder joints. Microspheroids containing hydroxyapatite crystals were seen by scanning electron microscopy in synovial fluid samples. All synovial fluids showed activated collagenase and neutral protease activity. This constellation of findings represents a heretofore undescribed syndrome which we have designated "Milwaukee shoulder."

Spheroid-shaped mass of hydroxyapatite crystals 1.9-15.6μ in diameter were found in 12 of 13 shoulder synovial fluids. Two of 16 control joint fluids also showed these particles. Collagen types I, II, and III were identified in the joint fluid pellets from three of the four patients, and fibers with typical collagen periodicity were also seen in transmission electron micrographs. Collagenase and neutral protease activities were found in fluids from five joints in three patients, whereas active collagenase was found in only one of ten fluids from rheumatoid arthritis patients and in none of three fluids from patients with osteoarthritis. Neutral protease activities were present in several rheumatoid joint fluids.

These findings are compatible with the hypothesis of an enzymatic release of hydroxyapatite crystals from the synovium, subsequent endocytosis by synovial macrophage-like cells with crystal-stimulated release of collagenase and neutral protease into the joint fluid, completing a pathogenetic cycle.

Synovial tissue excised from the unstable right shoulder joint of one of these patients with an absent rotator cuff, severe glenohumeral joint degeneration and hydroxyapatite-containing microspherules, collagen types I, II and III, active collagenase, and neutral protease in the joint fluid, showed extensive osteochondromatosis histologically. Electron microscopy revealed calcific foci in microvilli which had easy access into the adjacent joint space through areas denuded of synovial cells. Energy dispersive analysis showed elemental ratios of calcium and phosphorus consistent with hydroxyapatite. Whether similar synovial changes exist in the opposite shoulder joint of this patient and in three other subjects with very similar clinical, radiographic, and joint fluid findings is not known. ■

Tularemia in a Wisconsin resident—a reminder

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ABSTRACT. *After vacationing in New Mexico, a Wisconsin resident developed unilateral tender inguinal-femoral swelling with a punctate skin lesion on his thigh and protracted fever and malaise; he did not seek medical assistance until symptoms had persisted for over seven weeks. Tularemia was diagnosed by serologic criteria. A careful travel history, the risk of exposing laboratory personnel to the infectious agent, and appropriate diagnostic studies are important considerations in the differential diagnoses and evaluation of prolonged fever with suppurative adenopathy.*

TULAREMIA, ALSO known as rabbit fever or deerfly fever, is a common infection of small mammals which is transmitted to humans by direct animal contact, or by insect or arthropod vectors.[1,2] The disease is caused by *Francisella tularensis*, a Gram-negative coccobacillus, and may present as one of several clinical syndromes that include ulceroglandular, typhoidal, pneumonia, oculoglandular, or the oropharyngeal form. Vector-borne tularemia occurs most frequently west of the Mississippi River, notably in the southern and southwestern United States.[3] It is rarely reported as a health problem in Wisconsin.

We report here a serologically documented case of ulceroglandular tularemia in a Wisconsin resident following a vacation to New Mexico. Consideration of a recent travel history and knowledge of diseases endemic to various geographic areas is clearly important in the differential diagnoses of an unexplained acute febrile illness.

CASE REPORT. A 65-year-old white male was previously in excellent health with no prior hospitalizations. In September 1981 he drove to New Mexico for a fishing and camping trip, and he was unaware of any injuries or insect bites during his vacation. Three days after returning to Wisconsin he noted the onset of fever, sweats, fatigue, a small pustular right posterior thigh lesion and a swollen right groin. Over the subsequent four weeks he suffered daily fevers up to 103 F, drenching sweats, malaise, and persistent right groin swelling but did not seek medical attention. Thereafter, the fever and sweats resolved without medication, but because of malaise and continued right groin swelling he presented to the hospital in October 1981.

At the time of the initial assessment he had no symptoms other than those mentioned above, and he denied any prior drainage from the right groin area.

Physical examination showed a healthy appearing white male with temperature of 98 F, pulse rate 80 beats per minute, blood pressure 140/88 mmHG, and no diaphoresis. On the midposterior right thigh there was a 1x1 cm reddish lesion with a central es-

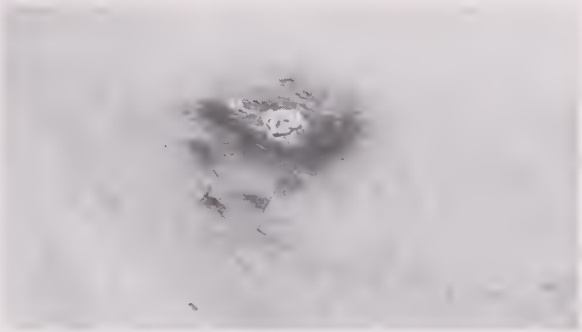

FIGURE 1—*View of right posterior thigh lesion with central eschar and surrounding erythema.*

FIGURE 2—*View of adjacent but non-confluent warm, tender right femoral (lower arrows) and right inguinal (upper arrows) subcutaneous masses.*

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char without drainage, warmth, or tenderness (Fig 1). Examination of the right groin disclosed two adjacent but nonconfluent 2x2 cm warm, tender, and mildly fluctuant right inguinal and femoral subcutaneous masses thought to be lymph nodes (Fig 2). There were no genital lesions, adenopathy elsewhere, or other skin lesions. The remainder of the physical examination was normal.

Initial laboratory studies included a white blood cell count of 7,000 per cu mm with a normal differential count, hemoglobin 14.6 Gm/dl, platelet count 375,000 per cu mm, blood urea nitrogen 14 mg/dl, creatinine 1.1 mg/dl, albumin 4.0 mg/dl, and normal liver function studies. A chest roentgenogram was normal.

Because tularemia was a possible diagnosis, lymph node aspiration was not performed. The patient was not hospitalized and a number of serologic studies were obtained as follows: tube and latex agglutination titers for sporotrichosis were negative, Brucella agglutination titer was <20, and micro-complement fixation titers for *Aspergillus fumigatus, Blastomyces dermatiditis, Candida albicans, Coccidiodes immitus* and Histoplasmin were all $<1:8$. Microagglutination titers for *Francisella tularensis* were 1:256 on presentation and four weeks later; and passive hemagglutination antibody titers to *Yersinia pestis* were negative (performed by Plague Branch, Center for Disease Control, Fort Collins, Colo).

The patient declined hospitalization, experienced spontaneous drainage of the right inguinal mass at home, and thereafter had resolution of all clinical symptoms. He agreed to outpatient therapy with oral tetracycline 2 Gm daily for 15 days, and remains clinically well as of January 1982.

DISCUSSION. Tularemia is a disease caused by the Gram-negative coccobacillus, *Francisella tularensis*, which is perpetuated in small mammal reservoirs in the southern and southwestern United States.[1-3] Humans acquire this infection by a number of possible mechanisms. During the summer and fall months, the organism is transmitted most commonly by infected hard ticks (*Dermacentor andersonii, Amblyomma americanum*), and during the winter months via contact with infected animals such as with rabbit hunting.[1,2]

Glandular or ulceroglandular tularemia accounts for over 60% of all cases. After an incubation period of three to five days, there is an abrupt onset of fever, chills, malaise, and tender adenopathy with an ulcerated skin lesion at the inoculation site. In tick-borne forms a lower extremity lesion with inguinal adenopathy is the most frequent clinical presentation, while animal handlers have a predominance of upper extremity lesions and adenopathy.[1,2]

Tularemia is infrequently encountered by practitioners in Wisconsin due to a paucity of infected reservoirs and vectors of this illness in our state. Although no cases of tularemia were reported in Wisconsin from 1977-1980, two serologically confirmed cases from Oconto and Marathon counties were recently published in the Wisconsin Epidemiology Bulletin (Vol 3, Number 6, September 1981). In the past, vector-borne afflictions were of greatest concern to physicians in those states where such diseases were endemic. However, these "high-risk" regions have become increasingly popular as areas for outdoor vacation pursuits, and travelers can contract disease and seek medical care only after their return to home states far distant from the endemic regions. Therefore, it seems advisable for physicians to be acquainted with the salient features of these infections.

The differential diagnosis of an acute febrile illness with associated suppurative adenopathy includes venereal diseases, mycobacterial and fungal infections, common bacterial adenitis (staphylococcal, streptococcal) and unusual bacterial infections such as brucellosis, plague, tularemia and *Pasteurella multocida* bite-associated infection. With so many considerations, a detailed historical account of travel, occupation and recreational exposure is imperative. Since tick bites are often unnoticed, as may have occurred in our patient, travel to an endemic region is sufficient to warrant consideration of an arthropod-borne illness.

When tularemia is the most likely diagnosis, it is inadvisable to aspirate lymph nodes for microbiologic studies. There is a low yield of positive cultures for *Francisella tularensis* even with the use of appropriate media, and more important, the aspirates are highly infectious and are hazardous to laboratory personnel handling the specimens. Rather, the diagnosis should rest on serologic documentation, with either four-fold titer change on serial specimens, or a single agglutination titer of 1:160, which is indicative of recent or past infection.[1,2]

With appropriate therapy mortality is less than 1% and relapse is rare. Untreated ulceroglandular tularemia is associated with one to ten percent mortality. It is unclear whether persons who "spontaneously" resolve the illness are at high risk for relapse, but it is generally recommended that a full course of therapy be administered to all patients. Streptomycin (15-20 mg/kg/day administered intramuscularly for seven to ten days) is the antimicrobial agent of choice; tetracycline and chloramphenicol are alternate agents but associated with higher relapse rates. Since organisms have not been shown to develop resistance to any of these medications, prolonged retreatment is appropriate for those patients who do relapse.

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While residual effects from Dalmane therapy are infrequent, patients should be cautioned about drinking alcohol, driving or operating hazardous machinery after ingesting the drug.

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Over 2000 clinical trials involving more than 10,000 patients have shown that Dalmane patients fall asleep sooner, sleep longer and experience fewer nocturnal awakenings.[4] The safety and efficacy of Dalmane have been demonstrated in medical and surgical hospitalized patients, in patients seen in office practice and in elderly patients.[5-8] Since the risk of oversedation, dizziness, confu-

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sion and/or ataxia increases with larger doses in the elderly, it is recommended that the dosage be limited to 15 mg.

Moreover, the efficacy and safety of Dalmane for the treatment of insomnia have been demonstrated in thousands of patients with a variety of primary medical conditions, including cardiovascular, neuropsychiatric, endocrine-metabolic, gastrointestinal, genitourinary, respiratory and musculoskeletal disorders.[1] Dalmane (flurazepam HCl/Roche) is contraindicated in pregnancy and in patients hypersensitive to the drug.

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Rebound insomnia—a worsening of sleep beyond pretherapy levels after drug discontinuation—has been reported as a potential clinical problem with some hypnotics.[9,10] However, this problem has not been reported with Dalmane. In eight out of eight sleep laboratory studies, there were no reports of rebound insomnia.[11] When you prescribe Dalmane, you can be confident of efficacy that enhances therapeutic progress. Your insomniac patients can be assured of a restful night, night after night—a good start for a good morning.

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Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphona, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

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Board names liaison committee on health care costs

The State Medical Society of Wisconsin's Board of Directors September 11 voted to consolidate all of the Society's cost containment activities in a new "Liaison Committee on Health Care Costs." The Board took the action in light of the high priority it has placed in recent months on cost effectiveness issues affecting business and labor.

The new committee will report to the Board and will absorb the current Cost Containment Committee under the Physicians Alliance Commission. Board Chairman Darold A Treffert, MD, Fond du Lac, has appointed the following physicians to serve on the Committee: Russell F Lewis, MD, Marshfield, chairman; Albert J Motzel Jr, MD, Waukesha; John J Kief, MD, Rhinelander, and members of the existing Cost Containment Committee: John O Simenstad, MD, Osceola; Guenther P Pohlmann, MD, Milwaukee; Harry J Zemel, MD, Fond du Lac; Jeremy R Green, MD, Green Bay; William C Miller, MD, Wausau; Raymond R Johnson, MD, Ladysmith; James V Seegers, MD, Elkhorn; George C Owen, MD, Milwaukee; and Fredrick Wood Jr, MD, Kenosha.

Meanwhile, business and labor liaison is continuing throughout the State with greater intensity and more specific cost-altering objectives.

- Marathon County Medical Society has held its second meeting with business representatives and will now focus on 1) general costs and 2) workers' compensation (disability, sick leave problems).
- Nelson Muffler Corporation, Stoughton, whose CEO is president of the Wisconsin Association of Manufacturers and Commerce, has asked SMS to co-host a meeting with all its plant managers and physician representatives from each area October 13.
- The Wisconsin Education Association Council and SMS are identifying patient and physician education as an important effort in cost effectiveness.
- The Medical Society of Milwaukee County is naming six physicians to a health care cost committee of the Milwaukee Metropolitan Area Association of Commerce.

Other Board Action September 11

Meeting in Madison, Saturday, September 11, the SMS Board of Directors:

- Approved an updated policy statement regarding utilization review.
- Approved proposed copy for a brochure explaining "Usual, Customary and Reasonable" charges. The brochure implements a 1982 House of Delegates resolution directing the Society to "inform Wisconsin physicians, employers and citizens that health insurance policies in which the insuror determines UCR are not necessarily 'total' coverage policies."
- Named the following physicians "Physician-Citizens of the Year" for 1982; Gordon L Backer, MD, Wausau; John N Richards, MD, Kenosha; and Warren H Williamson, MD, Racine. The three physicians were chosen to receive the award in recognition of their outstanding contributions to the communities and patients. Nominations for the award were received from county medical societies and local chambers of commerce in the state.

Dr Backer

Dr Richards

Dr Williamson

- Okayed a proposed program for the 1982 SMS Leadership Conference scheduled for November 12–13 at the Brookfield Marriott. Each county medical society and specialty society is strongly encouraged to be represented at this meeting.
- Heard a report that the Wisconsin Health Care Liability Insurance Plan (WHCLIP) Board of Governors is recommending to a legislative committee that WHCLIP be continued in its present form rather than be connected to a private company or eliminated.
- Was informed that Michael McManus, Executive Vice President of the Medical Society of Milwaukee County, will leave to become Chief Executive Officer of the Dade County (Florida) Medical Society on November 1. The Board extended its appreciation to him for his fine contributions to Wisconsin medicine.
- Reviewed a request from the Governor's Advisory Council for Women and Family Initiatives for the Society's endorsement of the Wisconsin Equal Rights Amendment. The Board concluded that WERA is a social-political issue outside medicine and is not an appropriate area for direct Society involvement, but noted for the record that the AMA and this Society have a long-standing commitment to equal opportunity and oppose sex discrimination in the medical profession.
- Approved SMS sponsorship of two seminars for resident physicians on the subject "Establishing a Practice." The afternoon seminars, to be conducted by the AMA Dept of Practice Management, will be held December 2 at the Medical College of Wisconsin in Milwaukee and December 3 at the UW Medical School in Madison.
- Established a standing committee on Health Practitioners to meet with representatives of the various health professions and share practice and educational concerns. The new

committee will consist of three members to be appointed by the SMS President for two-year terms.

• Agreed to increase *Wisconsin Medical Journal* "Yellow Pages" advertising rates from $16.00 minimum, or 40¢ per word, to $20.00 minimum, or 50¢ per word.

• Raised the *WMJ* subscription rate from $20 to $25.

• Appointed Robert T Cooney, MD, Portage, to the Joint Practice Committee with the Wisconsin Nurses Association.

• Removed from membership Francis Gilbert, MD, Kewaunee, following the revocation of his license by the Medical Examining Board.

• Reelected *Timothy T Flaherty, MD,* Neenah, and *Richard W Edwards, MD,* Richland Center, to the SMS Services, Inc Board of Directors. ■

SMS welcomes new staff member

The State Medical Society welcomes Deborah Bowen who has joined the staff as policy analyst in the Physicians Alliance Division. Ms Bowen most recently served on the staff of the Controlled Substances Board in the DHSS Bureau of Alcohol and Other Drug Abuse. She received her undergraduate degree from Illinois State University and her Masters of Science from the UW-Madison. ■

CES FOUNDATION

CONTRIBUTIONS—AUGUST 1982

The Charitable, Educational and Scientific Foundation of the State Medical Society is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for August 1982.

Nonrestricted

SMS Members—*Voluntary Contributions*

Restricted

Ohio Medical Products—*Other than CESF Projects*

NMC Projects, Inc—*Scholarship Fund*

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Dr-Mrs K Alan Stormo—*"Beaumont 500" Pledge (Museum of Medical Progress Endowment Fund)*

Memorials

Mrs Mark E Nesbit; Mrs J George Crownhart; Frederick L Chapman; Mr-Mrs F Chandler Young; Virginia H Purnell; Mr-Mrs Walter A Frautschi; Dr-Mrs John Van Gemert; Mr-Mrs Robert O'Malley; Elie M Asleson; Mr-Mrs Albert Kehm; Mrs Carl M Bogholt; Mr-Mrs RM Rieser Jr; LC Pomainville, MD; Wisconsin Division for Handicapped Children; Dr-Mrs EJ Nordby; Mr-Mrs Weber L Smith Jr; Mrs Margaret DuRose; Mrs Jerome H Coe; Grace Edmunds; Helen W Ostby; Marjorie Jothen; Harold E Kubly; Erna E Ziegel; Mr-Mrs Wilbur Renk; Josephine H Martin; Lillian M Gough; Mr-Mrs Robert W Taplick; Dr-Mrs F Jefferson Davis; Mr-Mrs Porter Butts; Russell F Lewis, MD; Dr-Mrs Stanley L Inhorn; Dr-Mrs Garrett A Cooper; Mr-Mrs Harold Koppel; Mr-Mrs Rudy Rosenau; Mr-Mrs Ira Baldwin; Mr-Mrs John W Fish; Mr-Mrs Robert Fish; Mr-Mrs Julian Harris; Joan Pyre—*H Kent Tenney, MD*

Joan Pyre—*Mrs N A Hill*

Mr-Mrs Earl R Thayer—*H Kent Tenney, MD ("Beaumont 500" Pledge—Museum of Medical Progress Endowment Fund)*

State Medical Society—*Edward L Martineau, MD; James R Schmidt, MD; John F Mokrohisky, MD; Edmund Sorenson, MD; John J Smith, MD; H Kent Tenney, MD; Jerome Jekel, MD* ■

MEMBERSHIP UPDATE

The following physicians, by county medical society, have recently been elected to membership, or have been reelected or reinstated since publication of the Membership Directory in the January issue of the *Wisconsin Medical Journal,* with the specialty abbreviated above the name:

BROWN

NS
Gruesen, Robert A
845 D S Webster Ave
Green Bay WI 54301

DANE

PD A
Bukstein, Donald A
1313 Fish Hatchery Rd
Madison WI 53715

IM
Friedman, Lisa C
202 South Gammon Rd
Madison WI 53717

N
Holoyda, Basil B
9 Colony Drive
Madison WI 53717

IM
Kaufman, Mark A
109 Vaughn Court
Madison WI 53705

FP
Kornaus, Paul A
10 Tower Drive
Sun Prairie WI 53590

IM
Sorber, David A
1313 Fish Hatchery Rd
Madison WI 53715

EAU CLAIRE-DUNN-PEPIN

IM
Fay, Cynthia J
1111 Stout Rd
Menomonie WI 54751

GREEN LAKE-WAUSHARA

FP
Winters, Thomas F
Hospital Rd, POB 279
Wautoma WI 54982

JEFFERSON

IM
Wishau, James P
120 East Oak St
Lake Mills WI 53551

LAFAYETTE

FP
McGreane, Norbert A
Rte 2, Box 187
Darlington WI 53530

LINCOLN

N
Goodell, Charles E
216 North 7th
Tomahawk WI 54487

MARATHON

IM
Ware, Robert J
Marathon WI 54448

MILWAUKEE

ORS
Brewer, Bruce J
8700 W Wisconsin Ave
Milwaukee WI 53226

GS
Malloy, Thomas G
9215 W Center St
Milwaukee WI 53222

P
Markson, John W
2266 N Prospect Ave, #601
Milwaukee WI 53202

R
Milbrath, John R
11339 Underwood Court
Wauwatosa WI 53226

OUTAGAMIE

PD
Merrick, James G
1108 Wylde Green Rd
Iowa City IA 52240

AI IM
Kagen, Steven L
103 W College Ave
Appleton WI 54911

IM PUD
Whiteside, Jeffrey R
1602 N Meade St
Appleton WI 54911

OZAUKEE

IM
McManus, Douglas B
326 West Pierre Lane
Port Washington WI 53074

PRICE-TAYLOR

IM
Frederick, T Bayard
789 S 7th Ave
Park Falls WI 54552

RACINE

ORS
Dussault, Michael C
156 Duane St
Burlington WI 53105

EM IM
Wagner, Richard F
10614 Seven Mile Rd
Franksville WI 53126

ROCK

GP
La Breche, Michael J
PO Box 351
Janesville WI 53545

SHEBOYGAN

AI IM
Beri, Vijay K
904 N 9th St
Sheboygan WI 53081

WAUKESHA

FP
Schroeder, George S
434 Madison St
Waukesha WI 53186

WOOD

IM
Przybylinski, John
1000 North Oak Ave
Marshfield WI 54449

NEP IM
Shaw, Gary H
1000 North Oak Ave
Marshfield WI 54449 ■

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MEMBERSHIP FACTS

ARE YOU A MEMBER of the State Medical Society of Wisconsin, or do you know someone who isn't? Whether you're just starting medical school, maintain a full-time practice, or are retired, SMS has a membership classification to fit your individual needs. Election to membership by the County Medical Society in which your principal place of practice is located carries with it membership in the State Medical Society of Wisconsin and, if you wish, the American Medical Association. If you qualify for resident membership at the time of your election, your membership dues are greatly reduced. This may also qualify you for reduced dues the first two years of your practice. Dues for regular membership in 1983 are $430 for SMS, $315 for AMA, and county society dues vary. A more detailed listing of SMS membership classifications and their corresponding dues follows:

State Medical Society of Wisconsin

DESCRIPTION OF MEMBERSHIP CLASSIFICATIONS

Regular: Member in active practice. Some are regular members that have reduced SMS and/or AMA dues because they are new practitioners (first year or two out of residency).

Resident: Physician who at January 1 of dues year is in an approved training program as a hospital resident or research fellow who is licensed to practice medicine and surgery in Wisconsin.

Military Service: Members who are serving in the U.S. armed forces (generally not to exceed five years).

Associate: Member whose dues are waived because of illness or financial hardship. This classification is temporary and is reviewed on an annual basis.

Life: Member who has held membership in a state medical society for 50 years or is a Past President of the State Medical Society of Wisconsin.

Honorary: Member who was named by the Board of Directors in recognition of long and distinguished service to the cause of medicine.

Retired: Member who has completely retired from practice (works less than 240 hours per year). All dues are waived unless county society indicates they wish to charge county dues.

Part-time Practice: Physician, regardless of age, who practices 1,000 hours or less during the calendar year but does not qualify for retired membership.

Over Age 70: Member in active practice who is over 70 years of age as of January 1.

Candidate: Member attending a medical school in Wisconsin or fulfilling a postgraduate obligation prior to eligibility for licensure.

Scientific Fellow: Member who is engaged in teaching one or more of the basic sciences at an accredited college or university, and not holding the degree of Doctor of Medicine or Osteopathy.

Emeritus: Retired members who have chosen not to renew their license.

1983 DUES AMOUNTS FOR THESE CLASSIFICATIONS

	SMS	AMA	COUNTY
Regular	$430	$315	Normal County Dues
Resident	43	45	Varies
Military Service	-0-	315 or 45	-0-
Associate	-0-	-0-	-0-
Life	-0-	-0-*	-0-
Honorary	-0-	-0-*	-0-
Retired	-0-	-0-*	-0-
Part-time Practice	215	315*	Normal County Dues
Over Age 70	215	-0-*	Normal County Dues
Scientific Fellow	-0-	-0-	
Emeritus	-0-	-0-*	
Candidate—			
Freshman Year Medical Student	-0-	15	Varies
Sophomore and Succeeding Medical Student Years	10	15	Varies
Postgraduate—One	10	45	Varies

*Due to recent policy changes by the AMA, future exemptions from AMA dues will be given to those physicians who are over 70 years of age *and* are retired from practice or practice 1000 hours or less a year.

State Society dues are prorated on a monthly basis for those elected to membership July 1 through September 30. Those elected after September 30 have no dues payable for the balance of the year in which they are elected. AMA dues follow the same pattern except prorating is on a semiannual basis rather than monthly basis.

15 MONTHS FOR THE PRICE OF 12!

In light of the change in membership policy allowing physicians to join their county and state societies and the AMA, or just their county and state societies, physicians are encouraged to join organized medicine now. Regular membership dues for 1983 are: $430 for SMS, $315 for AMA, and county society dues vary. However, physicians who join now will not pay any dues for the balance of 1982. That's 15 months for the price of 12! Membership applications may be obtained by contacting the secretary of your county medical society or by calling the Membership Department at the State Medical Society offices in Madison at 608/257-6781 or toll free: 800/362-9080. ■

SMS airs its views at Medicaid Forum

Benefits, utilization and reimbursement are clear targets for change in the Wisconsin Medical Assistance Program (WMAP), SMS Physicians Alliance Division Director Brian Jensen said at a special forum on future directions for the WMAP held by the Dept of Health and Social Services August 31 in Madison. The Society was one of 21 representatives from various provider and consumer organizations invited to the hearing.

Jensen agreed with the Department that it was time to quit clinging to "myths, generalities, or platitudes" in discussing cutbacks to the WMAP. Unfortunately, he said, many legislators still believe that the answer to WMAP costs is to cut provider reimbursement and/or shift costs elsewhere, including municipal government.

"Wisconsin is rapidly approaching a point of diminishing returns with respect to reimbursement limitations," he said.

Jensen urged the Department to do such things as: provide incentives for physicians to deliver certain procedures on an outpatient basis; institute limits on recipients regarding usage of emergency room services; and eliminate a host of optional benefits for all recipients, not just the medically needy.

In regard to physician services, Jensen said it would be inconsistent to suggest the above actions without corresponding cuts or limits in physician services. While reimbursement limits are about to be implemented under the program, he said, other limits could be instituted on such procedures as experimental surgery.

"Such limits exist in the private sector and the WMAP should be reviewed in a similar vein," he said.

Limits on access may be necessary according to Jensen. "Without tax dollars to support the program, Wisconsin may simply be forced to tell recipients they are authorized to have 'x' physician visits per year or per month."

On the psychotherapy issue, the Physicians Alliance Director said that in light of recent federal court decisions, the State is obligated to exempt all physicians from its community mental health board gatekeeper system. He encouraged the Department to establish a claims review mechanism which ensures that only medically indicated mental health services are reimbursed under the mandated services portions of the Medical Assistance Program. ■

Congress gets ready to act on FTC question

SMS President Gerald C Kempthorne, MD attended an emergency meeting called by the American Medical Association September 13–14 in Washington, DC on impending legislative action on the authority of the Federal Trade Commission (FTC) over the professions. Attending the session with Doctor Kempthorne were SMS Secretary Earl R Thayer and Assistant Secretary and Corporate Counsel HB (Bernie) Maroney.

While in Washington, the SMS representatives met with members of the Wisconsin Congressional Delegation to share the concerns of the medical profession on the issue.

Bills to define the FTC's proper role have been reported to the floors of both the House (HR 6995) and Senate (S 2499). While action on the bills was expected to occur by October 1, Congress delayed its vote on the matter as it rushed to recess for local election campaigns.

The issue will be taken up again in a "lame duck" session starting November 29 as part of the debate on extending the FTC's authorization. In the meantime, the agency will be operating on temporary funds that were provided through a last-minute continuing resolution that cleared both the House and the Senate October 1. ■

IN WASHINGTON, DC. . .SMS President Gerald C Kempthorne, MD; Assistant Secretary and General Counsel H B Maroney; Rep Thomas E Petri (R-Wis); and Secretary and General Manager Earl R Thayer.

Medical students participate in Summer Externship Program

Each year a group of medical students from Wisconsin's two medical schools take part in a unique educational experience—learning and living with a family physician in his/her Wisconsin community for the summer.

Forty-eight medical students this year participated in the 14th Annual Summer Externship Program sponsored by the Wisconsin Academy of Family Physicians (WAFP). The program is funded by the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin with contributions from the Rural Rehabilitation Corporation; American Family Insurance Company; Wyeth Laboratories; Wisconsin Physicians Service; Blue Cross-Blue Shield United of Wisconsin, and Employers Insurance of Wausau. In addition, individual physicians have contributed over $150,000 since the program has been in existence.

The WAFP matches a medical student from either the University of Wisconsin Medical School or the Medical College of Wisconsin, with a practicing Family Physician. Beginning in June the student spends a minimum of eight weeks working alongside his preceptor-physician, learning as much as he or she can about caring for individual patients and their families, learning to function in a community hospital, and learning how to utilize the various health resources in the community.

In most cases the student actually lives with the doctor in his home for the eight weeks.

Since its inception in 1969, the WAFP Summer Externship Program has provided an excellent learning experience for over 650 medical students from the two schools in Wisconsin, several of whom have now finished their undergraduate training and are now in a Family Practice Residency Program, preparing to enter Family Medicine in some Wisconsin community, or currently practicing in Wisconsin. This is the long-range goal of the sponsors of the program. . .to attract young medical students to practice in Wisconsin communities where there is a major need for family doctors.

The student spends his or her day with physicians in the office, in the hospital, in the operating room, and in home visits. He or she will also spend time visiting nursing homes, city or county health departments, homes for the aged, etc. This way the student becomes acquainted with all aspects of health within the community.

Listed below are the physicians or medical group and students who participated in the program this summer:

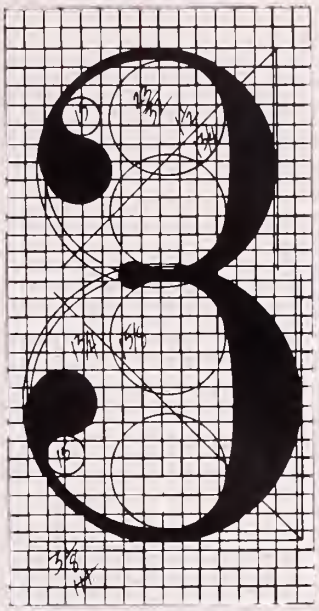
Physician/Medical Group *Student*	*City* *School*
Donald Beaver, MD Michael Volz	Milwaukee MCW
John Beck, MD Norbert Fahey	Sturgeon Bay MCW
John Grade, MD/Donald Wood, MD Mark Wisniewski Jerry Hartman	Brookfield MCW MCW
Doctors Clinic of Wis. Rapids Mary O'Connor	Wisconsin Rapids MCW
Stuart Goldman, MD Tami Helebrand	Milwaukee MCW
Bahri Gungor, MD John Zernia	Neillsville MCW
Richard Hanke, MD Karin Krygsman	Milwaukee MCW
Donald Heyrman, MD Mark Woodson	Menomonee Falls MCW
JS Jeffrey/WW Wolfmeyer, MD Nancy Sahakian	Kaukauna MCW
MS Kochar, MD Joy Rynda	Milwaukee MCW
Medical Assoc of Baraboo Scott Stillwell	Baraboo MCW
Roger Strube, MD Curt Zingheim	Milwaukee MCW
William E Wright, MD Paul Peterson	Mondovi MCW
Waukesha FP Program Brian Perkovich	Waukesha MCW
Darcy Jayne, MD Beverly Siersma	Mukwonago MCW
Glen Heinzl, MD Joe Cohen	Oconto MCW
Gregory Kuhr, MD Sue Weber	Greenfield MCW
Herbert Laufenberg, MD LeeAnne M Nazer	Cedarburg MCW
Richard O Barnes, MD Nancy Whereatt	Milwaukee MCW
Edward Kramper, MD Mike Medchill	McFarland MCW
Anselm Lam, MD Lee J Lawrence	Brown Deer MCW
Dennis Anderson, MD Mark Roznik	Milwaukee MCW
Ralph Whaley, MD Paul Johnston	Barron MCW
RJ Whitehouse, MD Yolanda Dickson	Madison UW
Michael Garrity, MD Kirk Jacobson	Prairie du Chien UW
DE Bates, MD Barb Amsler	Fort Atkinson UW

WH Williamson, MD Joyce Brandl	Racine UW
Tuenis Zondag, MD Lise Christensen	Eau Claire UW
TH Peterson, MD Dave McCarthy	Wausau UW
Donald Blink, MD Jesse Doers	Eau Claire UW
David Burnett, MD Sam E Kern	Sparta UW
Michael Kretz, MD Chris Knuth	Eagle River UW
EM Schammel, MD Tim Gundlach	Stoughton UW
Jack Brown, MD Shannon Sullivan	Sparta UW
John Koch, MD Emile Salvo	Prairie du Sac UW
Fred Melms, MD Brad Fedderly	Menomonie UW
Mich Mickkelson, MD Mark Torke	Merrill UW
David Nelson, MD Bill Owens	Stoughton UW
Richard Ellingstad, MD Phil Bain	Burlington UW
Paul Webber, MD Nisha Krishan	Burlington UW
Lawrence Heise, MD Branda Dierschke	Tigerton UW
Robert Justl, MD Hulon Crayton	Sun Prairie UW
Ralph Burnett, MD Larry Carbone Sharon Niccolazzi	Kenosha UW UW
RM Nesemann, MD Jeff Manlove	Kewaunee UW

■

The National Committee for Prevention of Child Abuse (NCPCA) publishes educational materials that deal with child abuse, child abuse prevention, and parenting. Selected titles have been translated into Spanish. The *NCPCA Catalog,* which describes these materials and gives ordering information, is available free upon request by writing to the Publishing Dept, 332 S Michigan Ave, Suite 1250, Chicago, IL 60604.

Disciplined Numbers



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Study probes physicians' views on future medical practice

The nation will have too many physicians within ten years, according to a national survey of doctors commissioned by the Henry J Kaiser Family Foundation. The physicians believe the surplus will bring changes in hours and services but will not lead to reduced physicians' fees, the study reported.

The study, based on interviews with a total of 1,814 physicians found that:

• The major group of concerns that physicians have about the future of medical practice related to loss of autonomy, mainly as a result of regulatory interference and governmental intervention. They are particularly disturbed by the anticipated growth of external controls of medical practice, and of fees. Relatively few doctors are complacent about restrictions by government or insurance carriers; many worry about further controls on such things as location and specialty.

• While self-employed, office-based practice remains the norm, there has been steady attrition over time as the result of a growing tendency toward salaried employment and toward hospital and group-based practice.

• While most physicians believe that an increase in the proportion of family practitioners is both likely and desirable, there is no indication of increased interest in this field of practice and there is considerable concern about restricted opportunities for specialty practice.

• Physicians appear quite responsive to the introduction of physicians' assistants and nurse practitioners to provide diagnostic and therapeutic services to underserved population groups. However, in the face of physician oversupply, physicians may become increasingly reluctant to endorse the use of physicians' assistants and nurse practitioners where they appear to be competing with doctors.

• Nearly half of all physicians and more than half of the residents think their practices will be affected by prepaid plans over the next ten years.

• The most commonly acknowledged effect of local prepaid groups upon other physicians in the community is that they have caused them to consider joining or forming an IPA or closed-panel HMO.

• Most physicians not working in HMOs have generally negative views of HMOs. While they acknowledge that HMOs are at least somewhat effective in containing costs, most physicians believe that the HMO stress on cost containment may lower the quality of their health care services to an unacceptable level.

• Residents have much more favorable opinions of HMOs than practicing physicians. Many residents may be attracted to a career in an HMO.

• There is no significant difference in the extent of board certification, board eligibility, or experience among physicians in prepaid traditional practice. To the extent that experience and board certification are criteria, criticisms that have been expressed of the quality of HMO physicians are not borne out.

• Closed-panel HMOs are perceived to be more cost-effective and financially viable than IPAs. They are also perceived by physicians to be more likely to provide a lower quality of care and of physicians.

• Most closed-panel HMO physicians plan to spend their entire careers in prepaid practice. Politically, HMO physicians tend to be more liberal. They are also less likely to be members of medical societies than other practitioners. ■

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Dane County physician receives preceptor honor

William T Russell, MD was awarded the 1982 Doctor Max Fox Preceptor Award of the University of Wisconsin's Medical School at the Dane County Medical Society Meeting October 12 in Madison. UW Medical School Dean Arnold L Brown, MD presented Doctor Russell with the award.

Doctor Russell, a family practitioner in Sun Prairie for 33 years, has introduced medical students to the profession through the University of Wisconsin Medical School's Preceptor Program with understanding and dedication. For 16 years medical students were shown the real world of family practice as they worked with Doctor Russell at the office, at the hospital, and even spent nights at his home when he was on call.

Doctor Russell graduated from the University of Wisconsin Medical School in 1946 and served his internship at St Mary's Hospital, Madison. He began his practice in Waterloo, Wisconsin in 1947 and moved to Sun Prairie in 1949.

Through the years he has served on many important commissions and committees of the State Medical Society and the Dane County Medical Society and has been active in community activities. ■

DANE: The Nominating Committee of the Dane County Medical Society met August 31 at its executive offices in the SMS Headquarters building in Madison to select a slate of candidates for next year's offices. A list of nominees follows:

President-elect: Peter L Eichman, MD,* Madison
Vice-president: Howard S Lubar, MD,* Madison
Secretary-treasurer: Kathryn P Nichol, MD,* Madison
(The above three offices are for one-year terms.)
Delegate: Robert B Shapiro, MD,* Madison
(to succeed himself)
Alternate: Charles J Anderson, MD,* Madison
(to succeed himself)
Delegate: Milfred A Cunningham, MD,* Madison
(to succeed himself)
Alternate: Ronald D Wenger, MD,* Madison
(to succeed William J McAweeney, MD,* Madison)
Delegate: Charles H Geppert, MD,* Madison
(to succeed himself)
Alternate: Paul A Wertsch, MD,* Madison
(to succeed Robert L Cole, MD,* Madison)
Delegate: David L Nelson, MD,* Stoughton
(to succeed himself)
Alternate: A Paul Vastola, MD,* Madison
(to succeed himself)
Delegate: David W Semian, MD,* Madison
(to succeed himself)
Alternate: Victoria A Vollrath, MD,* Madison
(to succeed John M Nelson, MD,* Madison)
Delegate: Richard W Shropshire, MD,* Madison
(to succeed himself)
Alternate: Richard O Welnick, MD,* Madison
(to succeed himself)
Delegate: Robert L Cole, MD,* Madison
(to succeed Charles H Mann, MD,* Madison)
Alternate: Joseph F Sackett, MD,* Madison
(to succeed himself)
Delegate: Klaus D Diem, MD,* Madison
(to succeed himself)
Alternate: Robert A McDonald, MD,* Madison
(to succeed Gary W Woroch, MD,* Madison)
(All delegates and alternates are elected to a term of two years and take office on the next ensuing January 1 after their election.)

Election will take place at the October 12 Annual Meeting of the DCMS at its executive offices in Madison.

The Nominating Committee consists of MDs Sandra L Osborn,* Madison, chairman; Robert P J Christmann,* Madison; Thomas F Heighway,* Middleton; John H Morledge,* Madison; Joseph F Sackett,* Madison; and Alwin E Schultz,* Madison, ex officio.

DANE: Dane County Medical Society members are being encouraged to use a new simplified form for reporting communicable diseases in Dane County. Diseases to be reported to the local health department include tuberculosis, hepatitis A and D, and preventable diseases. The new forms are available from the Madison Public Health Department and the Dane County Health Department.

KENOSHA: Forty members were present at the September meeting of the Kenosha County Medical Society to hear Stephen D Hathway, MD,* Green Bay, speak on the experiences of creating the Brown County Health Care Coalition. Gerald C Kempthorne, MD,* Spring Green, president of the State Medical Society of Wisconsin, was also a guest speaker.

POLK: At the August meeting of the Polk County Medical Society, twenty members were present to hear Dr Leonard Wilson, chairman of the History Department at the University of Minnesota Medical School, speak on "Search for Safe Milk for Infants." John O Simenstad, MD,* Osceola, discussed the latest Medicaid proposal of fee schedule at the business portion of the meeting.

WINNEBAGO: Sixty-seven members and six guests were present at the September meeting of the Winnebago County Medical Society. Guest speakers included Andrew B Crummy Jr, MD,* Madison, who spoke on "Digital Angiography" and Brian Jensen, Madison, Director of the Physicians Alliance Commission of the State Medical Society. Mr Jensen discussed the Department of Health and Social Services fee structure. ■

Physician Briefs

*Physician members of State Medical Society of Wisconsin

Carl J Chelius, MD,* Cudahy, recently was elected to fellowship in the American College of Cardiology. Doctor Chelius is director of electrocardiology at Trinity Memorial Hospital and has been a member of the medical staff since 1960. A member of the Fine-Lando Clinic, Cudahy, he also serves as the city's health commissioner and is an assistant professor of medicine at the Medical College of Wisconsin in Milwaukee.

John P Kiser, MD,* Green Bay, recently became associated with Physicians in Family Practice in Green Bay. Doctor Kiser graduated from the Medical College of Wisconsin, Milwaukee, and completed his residency at the Medical College of Wisconsin Affiliated Hospitals.

JG Kotynek, MD, Superior, recently joined the medical staff of the Superior Clinic, Ltd. A graduate from the University of Illinois School of Medicine, Doctor Kotynek completed his internship and residency at the University of Wisconsin in Madison.

GG Karwoski, MD, Superior, recently became associated with the medical staff of the Superior Clinic, Ltd. Doctor Karwoski graduated from the Washington University School of Medicine, St Louis, Mo, and completed his residency at the University of Minnesota Hospitals in Minneapolis.

Folkert O Belzer, MD,* professor and chairman of surgery at the University of Wisconsin Medical School, Madison, has been named the first Anthony R Curreri professor of surgery. The Curreri professorship recognizes clinical, scholarly, and teaching excellence. Doctor Belzer is internationally known for his work in kidney transplantation and has been a member of the UW medical school faculty as chairman of surgery since 1974. Anthony R Curreri, MD, had been a member of the UW faculty since 1939 and had served as director of the Division of Clinical Oncology, chief of staff, and chairman of surgery. He died in 1979.

Robert T Obma, MD,* La Crosse, has been elected to fellowship in the American College of Cardiology. Doctor Obma is a graduate from the University of Wisconsin Medical School, Madison, and is currently a preceptor at the University of Wisconsin Medical School. He also is a member of the medical staff of the Skemp-Grandview-La Crosse Clinic in La Crosse.

George J Korkos, MD,* Milwaukee plastic surgeon, recently was named to the Federal Rank Review Board, which advises the president on nominations of federal employees for meritorious monetary awards. Doctor Korkos also is a team physician for the Milwaukee Bucks basketball team.

Charles Bricker, MD, Superior, recently opened his medical practice at Superior Memorial Hospital. Doctor Bricker graduated from Indiana University School of Medicine and completed his residency at the Medical College of Wisconsin in Milwaukee.

James Bargenquast, MD, Superior, has opened his medical practice at Superior Memorial Hospital. A native of Milwaukee, Doctor Bargenquast graduated from St Louis University School of Medicine and completed his residency at the Medical College of Wisconsin in Milwaukee.

Rolando R Buan, MD,* Tomah, recently became associated with the branch clinic of the Gundersen Clinic in Tomah. Doctor Buan graduated from the Far Eastern University Medical School in the Philippines, and served his internship at the US Air Force Hospital, Clark Air Base, The Philippines, and at Mount Sinai and St Mary's hospitals in Milwaukee. He also completed a fellowship at St Joseph Hospital in Milwaukee. He is a member of the board of directors and chief of the medical staff at Tomah Memorial Hospital.

James F Girolami, MD,* Tomah, former instructor and assistant professor at the Medical College of Wisconsin, Milwaukee, recently joined the medical staff at the branch clinic of the Gundersen Clinic in Tomah. Doctor Girolami graduated from the University of Washington School of Medicine, Seattle, and completed his residency at Deaconess Hospital in Milwaukee.

Kevin A Jessen, MD, Tomah, has joined the medical staff of the Gundersen Clinic at the branch office in Tomah. Doctor Jessen graduated from the University of Minnesota Medical School in Minneapolis. He completed his residency in family practice at the Southwestern Michigan Area Health Education Center in Kalamazoo.

Bradley W Poulson, MD, Manitowoc, recently joined the medical staff of the Memorial Hospital, Manitowoc. A graduate from the Wayne State University School of Medicine, Doctor Poulson served his residency at St Joseph Hospital in Detroit.

John E Hoggatt, MD, Stevens Point, recently became associated with the Rice Clinic in the Department of Pediatrics. Doctor Hoggatt graduated from Northwestern University School of Medicine, Evanston, Ill, and served his internship at Hennepin County General Hospital in Minneapolis. His residency was completed at Children's Memorial Hospital in Chicago. Prior to joining the Rice Clinic, Doctor Hoggatt was on the medical staff at New Ulm Medical Clinic and Sioux Valley Hospital in New Ulm, Minn.

Mark W Sharon, MD, Plymouth, recently began his medical practice and is associated with the medical staff of the Plymouth Hospital. Doctor Sharon graduated from the Medical College of Wisconsin, Milwaukee, and completed his residency in family practice at the Rockford Medical Foundation in Illinois. Prior to moving to Plymouth, he served on the emergency medical staff of Swedish-American and St Anthony Hospital Medical Center in Rockford.

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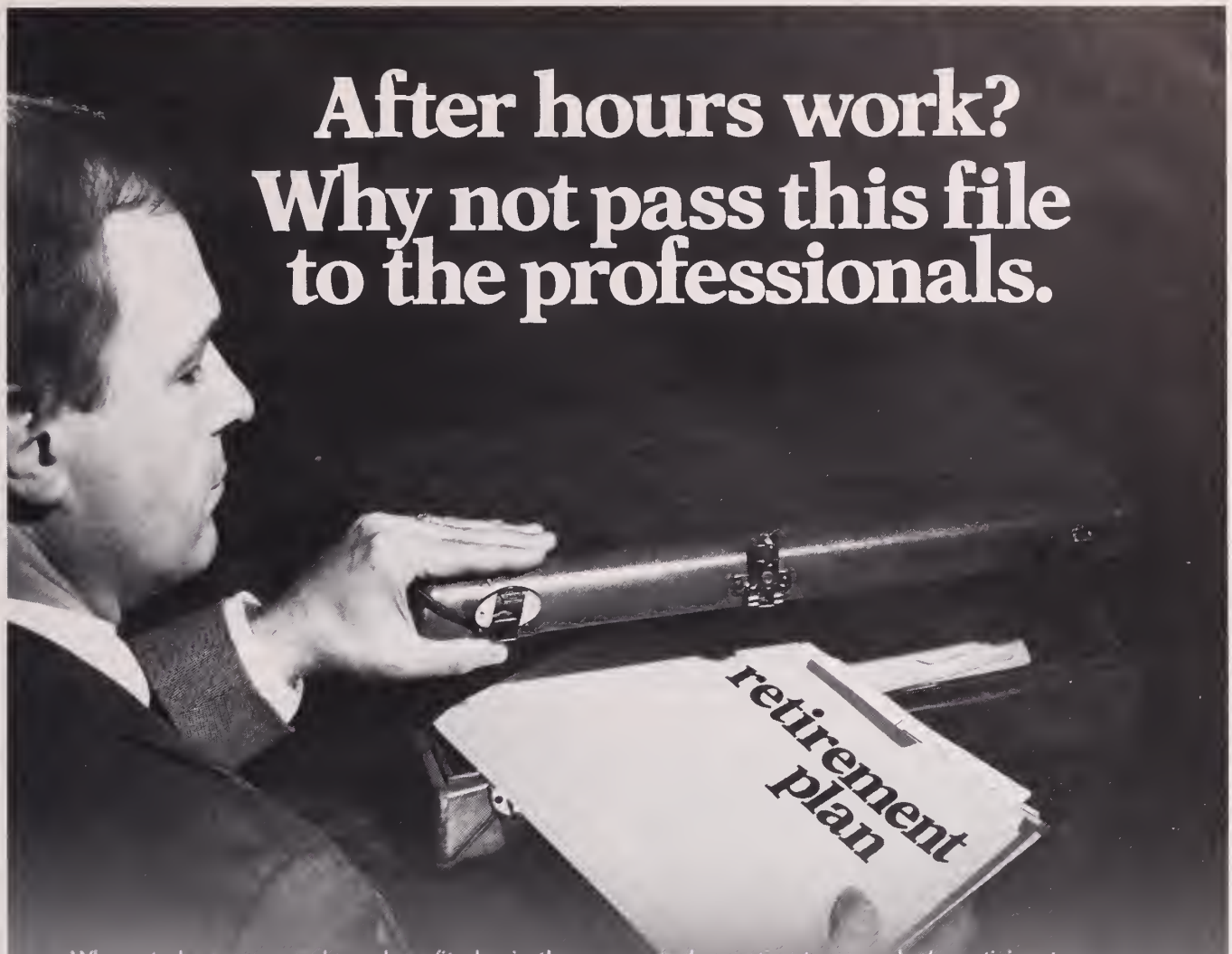

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Arnold Rosenthal, MD, Madison, recently became associated with Diana L Kruse, MD,* in Sauk City. A graduate from Dartmouth Medical School, Doctor Rosenthal completed his residency in orthopedic surgery at University Hospital and Clinics in Madison. He also is a member of the medical staff of Sauk-Prairie Memorial Hospital.

Charles E Syrjamaka, MD, Green Bay, recently became associated with MDs Richard E Jensen,* Robert J Rose,* and Omer Sanen in Green Bay. Doctor Syrjamaki graduated from the University of Michigan Medical School and completed his residency at the University of Nebraska Medical Center.

James B Unger, MD and **George L Hill, MD,** Marshfield, recently became associated with the medical staff of the Marshfield Clinic. Doctor Unger graduated from the Abraham Lincoln School of Medicine, Chicago, and completed his residency in obstetrics and gynecology at the University of Mississippi Medical School in Jackson, Miss. Doctor Hill graduated from the Oklahoma University College of Medicine at Oklahoma City and Tulsa. He completed his residency in obstetrics and gynecology at the Tulsa Medical College Affiliated Hospitals in Tulsa.

Carol L Magnuson, MD, Chetek, recently became associated with the Midelfort Clinic-Barron. Doctor Magnuson graduated from the University of Tennessee, Memphis, and completed her residency in pediatrics at the University of Minnesota Hospitals. She previously practiced in St Paul before joining the medical staff of the Midelfort Clinic-Barron.

Burton F VanderLaan, MD, Beloit, recently joined the medical staff of the Beloit Clinic, SC, in the Department of Internal Medicine and Oncology. Doctor VanderLaan graduated from the University of Chicago and completed his residency at Michael Reese Hospital in Chicago. He had been an instructor at the University of Chicago prior to joining the Beloit Clinic.

Mark S Perpich, MD, Janesville, has become associated with the Janesville Orthopedic Surgery Group. A graduate from the University of Wisconsin Medical School, Madison, he completed his residency at University Hospital and Clinics in Madison.

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David Nye, MD, Eau Claire, recently became associated with the medical staff of the Midelfort Clinic. Doctor Nye graduated from the University of Vermont and completed an internship at Montefiore Hospital in Pittsburgh. His residency in neurology was completed at the University of Pittsburgh.

Martin Voss, MD, Eau Claire, has become associated with the medical staff of the Midelfort Clinic in the Department of Allergy. A graduate from the University of Wisconsin Medical School, Madison, he completed a residency in pediatrics at the Mayo Clinic, Rochester, and recently completed an allergy fellowship from the University of Wisconsin Medical School, Madison.

Ronald E Roup, MD, Green Bay, recently became associated with the Deckner Medical Center. Doctor Roup graduated from the University of Wisconsin Medical School, Madison, and served his residency in pediatrics at the University of Nebraska Medical Center. He also was chief resident at the center and at Children's Memorial Hospital in Omaha.

Thomas P Koehler, MD, Green Bay, a graduate from the Medical College of Ohio in Toledo, recently joined the medical staff of the Deckner Medical Center. He completed his residency training at the Medical College of Ohio and served as emergency physician at Defiance Hospital, Defiance, Ohio, before moving to Green Bay.

Raymond G Bachhuber, MD, Green Bay, has joined the medical staff of the Deckner Medical Center. A graduate from the University of Wisconsin Medical School, Madison, he completed his residency at the University of Oregon Health Sciences Center, Portland, where he also was chief resident in the Department of Medicine.

Jane C Smith, MD,* Monroe, recently joined the medical staff of The Monroe Clinic. Doctor Smith graduated from Baylor University School of Medicine, Houston, Tex, and served an internship and residency in general psychiatry at St Mary's Hospital in San Francisco, Calif. Doctor Smith has been a clinical instructor in the Department of Psychiatry at the University of Wisconsin, Madison, and recently completed a fellowship in geriatric psychiatry at William S Middleton Memorial VA Hospital in Madison prior to joining The Monroe Clinic.

Albert J Motzel, Jr, MD,* Waukesha, immediate past president of the State Medical Society, recently spoke in Green Bay at the health care cost containment seminar. The theme of the seminar was "The Keys To Health Care Cost Containment" and Doctor Motzel's speech was entitled "Providers' View On Cost Containment." The seminar was sponsored by the North Central Area Health Planning Association, Wausau.

Charles L Stimpson, MD, Chetek, recently joined the medical staff of the Midelfort Clinic-Chetek. He graduated from the University of Tennessee Center for the Health Sciences in Memphis and completed his residency training at Fairview and St Mary's hospitals in Minneapolis, Minn.

Lee M Robak, MD and **Steven E Waltman, MD,** recently opened their medical practice at the Sun Prairie Family Practice Center. Doctor Robak graduated from the University of Iowa Medical School and Doctor Waltman graduated from the University of South Dakota Medical School. They completed their residency programs with the Sioux City Family Practice Residency Program in Iowa.

Kathleen Burchby, MD, Milwaukee, recently became associated with the medical staff of the Milwaukee Medical Clinic. Doctor Burchby graduated from Southern Illinois University School of Medicine and completed her internship and residency at Milwaukee Children's Hospital.

Mark Belknap, MD, Ashland, recently joined the medical staff at Memorial Medical Center. He graduated from the University of Minnesota Medical School and completed his residency at Hennepin County Memorial Hospital, Minneapolis, where he also served as chief resident in the Department of Internal Medicine. He is associated with Frank J Cadwell, MD.*

John L Felton, MD, Monroe, recently joined the medical staff of The Monroe Clinic. An ophthalmologist, he graduated from Indiana University Medical School and completed his internship and residency at Akron City Hospital in Ohio. He is a member of the medical staff at St Clare Hospital.

Robert Schmus, MD, Watertown, recently opened his medical practice in Watertown. A native of Brookfield, he graduated from the Medical College of Wisconsin in Milwaukee. He also completed his residencies in general and vascular surgery at the Medical College.

Joseph S Fok, MD, Fort Atkinson, recently opened his medical practice in Fort Atkinson. He graduated from the University of Wisconsin Medical School, Madison, and completed his residencies in OB-GYN at University of Wisconsin Affiliated Hospitals, Madison. He is a member of the medical staff of Fort Atkinson Memorial Hospital.

Paul Jensen, MD, formerly of Escanaba, Mich, has joined the medical staff of the Hayward Medical Group in the department of family practice. Doctor Jensen graduated from Wayne State Medical School, Detroit, and served his residency at Marquette General Hospital in Marquette, Mich. He served as president of Wayne State Family Practice Club and also as chairman of the Students' Committee of Michigan Academy of Family Physicians.

Robert J Aylesworth, MD, Rhinelander, recently became associated with the W S Bump Medical Group SC. A dermatologist, Doctor Aylesworth graduated from the University of Wisconsin Medical School, Madison, and completed his residency at the University of Minnesota in Minneapolis.

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David Swartwood, MD, Ashland, recently became associated with the medical staff at Memorial Medical Center. He is associated with Frank J Cadwell, MD,* in the Department of Internal Medicine. Doctor Swartwood graduated with a pharmacy degree from South Dakota State University in Brookings, and also graduated from the University of Minnesota School of Medicine in Minneapolis. He completed his residency at the Hennepin County Medical Hospital in Minneapolis.

Donald E Hoff, MD,* Eau Claire, has joined the medical staff at the University of Wisconsin-Eau Claire replacing William T Mautz, MD,* as campus physician. Doctor Hoff, an Eau Claire physician for nearly 30 years, graduated from the University of Kansas School of Medicine and is a member of the medical staff of Luther and Sacred Heart hospitals in Eau Claire.

Ely Epstein, MD,* Milwaukee, has joined the medical staff of the Milwaukee Medical Clinic. A graduate of the Northwestern University School of Medicine, Doctor Epstein completed his residency in pediatrics at Michael Reese Hospital, Chicago. A clinical professor of pediatrics at the Medical College of Wisconsin, Doctor Epstein is on the medical staff of Milwaukee Children's Hospital, Mount Sinai Medical Center, and Columbia Hospital. ■

News Highlights

*Physician members of State Medical Society of Wisconsin

St Alphonsus Hospital, Port Washington, has announced the promotion of Mr Richard Gierczak to assistant administrator of operations and the appointment of Edward L Bradley as director of planning and development. Mr Gierczak has served as director of financial services since 1975. Mr Bradley, prior to joining St Alphonsus, had been with Methodist Manors in Milwaukee. St Alphonsus Hospital is a 94-bed acute care general hospital and Henry J Katz, MD,* Port Washington, is chief of the medical staff of 90 physicians.

The Marcus Corporation Foundation recently committed $60,000 to the Medical College of Wisconsin to establish the Marcus Center for Immunological and Allergy Research. The center will be directed by Jordan N Fink, MD, Milwaukee, professor of medicine and chief of allergy, and Robert H Keller, MD, Milwaukee, associate professor pediatrics. The center will be located at the Veterans Administration Medical Center, Wood. The Medical College of Wisconsin is a nationally recognized center for the study of allergic diseases and Doctor Fink is an international authority on unusual allergic disorders.

American Association for Clinical Chemistry at its 34th national meeting held at Anaheim, California, presented awards to the following recipients from Wisconsin. They are Harry F Weisberg, MD,* Milwaukee, Mt Sinai Medical Center, "Outstanding Efforts in Education and Training;" Edward A Sasse, PhD, Milwaukee, Medical College of Wisconsin, "Fellowship to Promote Clinical Chemistry in a Foreign Country;" and James O Westgard, PhD, Madison, University of Wisconsin Medical Center, "Outstanding Contributions to Clinical Chemistry."

Waupun Memorial Hospital has named Moriano L Rosales Jr, MD, Waupun, as its new chief of staff, and Theodore Rowan, MD,* Waupun, as the new staff secretary. Doctor Rosales has been a member of the medical staff of the hospital since 1979 and had served as staff secretary in 1981-82. Doctor Rowan, a native of Great Britain, has been a member of the medical staff since 1961 and had served as chief of staff in 1956-66 and also as staff secretary in 1963-67.

Newly elected officers of St Luke's Hospital medical staff, Racine, are pictured above from left to right: Dennis J Kontra, MD,* secretary; Howard I Gass, MD,* president (seated); and Claude E Oberdorfer, MD,* treasurer. Not pictured is Charles W Christenson, MD,* vice-president and president-elect. ■

Obituaries

G Thomas Rahilly, MD, 35, Rochester, New York, died July 24, 1982 in Rochester. A native of Franklin, Ky, Doctor Rahilly had been associated with the Greenwood Clinic from 1976 to 1978 prior to moving to Rochester. He was a member of the medical staff of Strong Memorial Hospital and headed electrophysiology, a specialized unit within the cardiology department. Surviving are his widow, Anne; and three daughters, Katy, Louisa, and Elizabeth.

James R Schmidt, MD, 49, Wauwatosa, former associate professor at the Medical College of Wisconsin, died July 29, 1982 in Milwaukee. Born Apr 20, 1933 in Milwaukee, Doctor Schmidt graduated from Marquette School of Medicine in 1958 and served his internship at St Joseph's Hospital in Milwaukee. His residency was completed at the Veterans Administration Hospital, Wood. Doctor Schmidt was on the medical staff of St Francis, St Joseph's, St Luke's, Milwaukee Children's hospitals, and the Good Samaritan Medical Center. He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association. Surviving are his widow, Jean; two sons, James A and Michael T; and two daughters, Susan M and Jennifer J, all at home.

John F Mokrohisky, MD, 60, Green Bay, died July 30, 1982 in Green Bay. Born June 24, 1922 in Binghamton, New York, Doctor Mokrohisky graduated from Marquette University School of Medicine in 1948 and served his internship at Binghamton City Hospital in New York. His residency in radiology was completed at Bellevue Medical Center, New York; Beth Israel Hospital, Boston; and at Temple University Hospital in Philadelphia. He was chief radiologist at Our Lady of Lourdes Hospital, Binghamton, New York, and in 1958 he moved to Green Bay to become chief of radiology at St Vincent Hospital where he established a nuclear medicine and radiation therapy program. He was a member of the Wisconsin Radiological Society, Brown County Medical Society, State Medical Society of Wisconsin, and the American Medical Association. Surviving are his widow; two sons, John Jr and Mark, Green Bay; and one daughter, Pamela of Las Vegas, Nev.

Edmund D Sorenson, MD, Elkhorn, former president of the State Medical Society of Wisconsin in 1960, died July 30, 1982 in Elkhorn, Born Sept 10, 1895 in Beaumont, Doctor Sorenson graduated from Marquette University School of Medicine in 1923. He served his internship at St Mary's Hospital in Milwaukee. Doctor Sorenson served in the United States Army during World War I. He had practiced medicine in Elkhorn from 1924 until he retired in 1980. He had served as medical adviser to the Walworth County Selective Service Board for 29 years and also had served as president of the medical staff of Lakeland Hospital. Active in community affairs, he was honored by the Elkhorn Women's Club in 1959; by the Lions Club as outstanding citizen in 1973; and in

Doctor Sorenson

1978, was honored by the Lakeland Hospital medical staff and the Walworth County Board of Supervisors for his devotion to the community. Doctor Sorenson had served as president of the Walworth County Medical Society and had also served as a delegate to the State Medical Society of Wisconsin of which he was president in 1960-61. He also was a member of the American Medical Association. Surviving are two sons, Edmund H of Hinsdale, Ill and Joseph A of Elgin, Ill. In addition to his wife, Mildred, he was predeceased by a son, Dr Robert Sorenson.

John G Beck, MD, 75, Sturgeon Bay, died Aug 2, 1982 in Sturgeon Bay. Born Feb 20, 1907, in Lockport, Ill, Doctor Beck graduated from Northwestern University Medical School in 1933 and served his internship in Pittsburgh, Pa. Doctor Beck had previously practiced in Titusville, Pa, before beginning his medical practice in Sturgeon Bay in 1941. He retired in 1974. Doctor Beck organized the first day care center in Sturgeon Bay and after World War II, he was a physician for German prisoners in Door County. He was well known in the State for his involvement in scouting. Surviving are a daughter, Mrs Ted (Coralee) McDonald, Castle Rock, Wash, and a son, Dr John J Beck of Sturgeon Bay.

John Joseph Smith, MD, 56, Shorewood, died suddenly Aug 5, 1982 at home. Born Sept 1, 1925 in Freeport, Ill, Doctor Smith graduated from the College of Physicians and Surgeons of Columbia University in 1949. He served in the United States Navy Medical Corps during the Korean War. He served his internship at Milwaukee County General Hospital and completed his residency in internal medicine there in 1956. He was an associate Clinical Professor of Medicine at the Medical College of Wisconsin. From 1958 to present Doctor Smith was in private practice and also was the medical director for the Allen-Bradley Company since 1976. He was on the medical staff of St Mary's and Deaconess

hospitals. He was certified by the American Board of Internal Medicine and was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, the American Medical Association, and the American Occupational Medicine Association. Surviving are his widow, Jane Ann; and five sons, David, Glendale; Scott, Milwaukee; and Jeffrey, William and Peter of Shorewood.

Jerome M Jekel, MD, 75, Naples, Fla, died Aug 11, 1982 in Naples. Born Oct 28, 1906 in Milwaukee, Doctor Jekel graduated from Marquette University School of Medicine and served his internship at St Mary's Hospital in Milwaukee. Doctor Jekel had his medical practice in Milwaukee for 42 years before moving to Naples, Fla, in 1974. He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and the American Medical Association. Surviving are his widow, Marie, and daughter, Susan of Milwaukee.

H Kent Tenney, MD, Madison, 90, president of the State Medical Society of Wisconsin in 1953-54, died Aug 15, 1982 in Madison. Born on May 11, 1892 in Chicago, Ill, Doctor Tenney graduated from Northwestern Medical School in 1919 and served his internship at Evanston Hospital, Evanston, Ill. Doctor Tenney was a proud descendant of an Ottawa Indian Chief and of a pioneer Wisconsin medical family. He came to Madison in 1920 and was one of the first of his specialty, pediatrics, to begin a practice which has led to several related and distinguished careers. He was probably best known for his "March of Medicine" radio programs, broadcast weekly from 1960 until 1976, when he retired at the age of 83. Doctor Tenney was an emeritus professor of pediatrics at the University of Wisconsin Medical School, and a winner of the Medical School's Emeritus Faculty Award. He was the prime developer of the childcare projects, known as "Well Baby Clinics," and a widely read author, having written the popular book "Let's Talk About Your Baby." He served as chairman of the Governor's Conference on Children and Youth in 1953; directed the Wisconsin survey on child health in 1946, and in 1948 he was chosen chairman of the technical committee set up by the interim committee of the Legislature to study the State Board of Health. He served as chairman of the Wisconsin Chapter of the American Academy of Pediatrics, served on the board of directors, and in 1961 was named "Man of the Year" for the Wisconsin Association of Mental Health. In 1961, Doctor Tenney received the highest honor of the State Medical Society, the "Council Award." He is a past president of the Dane County Medical Society and also served as speaker of the House of Delegates of the State Medical Society. He also was a member of the American Medical Association. Surviving are his widow, Jeanette; three sons, Thomas W Tenney, Berkeley, Calif; Horace K Tenney, MD, Madison; and H Baird Tenney of Cleveland, Ohio.

Dr Tenney

Frank L Weston, MD, 84, Madison, prominent physician, died Sept 1, 1982 in Madison. Born June 25, 1898 in Thornton, Iowa, Doctor Weston attended the University of Wisconsin and graduated in 1921. He obtained his medical degree from Rush Medical School, Chicago, in 1923 and served his internship at Cook County Hospital. He returned to the University of Wisconsin in 1925 and remained a member of the faculty until his retirement in 1968. In 1969 he received the 10th Emeritus Faculty Award from the University. In 1920 he was an all-American end on the University's football team and he also served for 16 years on the UW Athletic Board. The Medical School library at the UW Clinical Sciences Center was named in his honor in 1978. In 1956 he received the "Distinguished Service" citation of the Wisconsin Alumni Association. Doctor Weston was elected to the Madison Sports Hall of Fame in 1965. In 1966 he received the "Council Award" of the State Medical Society and he had also served as treasurer of the Society from 1951-1975. Since 1950 he had been chairman of the state volunteer medical advisory committee and in 1972 was presented the Selective Service Silver Medal for exceptional service by the State Selective Service. In 1973 Doctor Weston began making the "Weston Walker," a popular walking stick and it has been estimated he had made over 1,000 of the sticks, giving them to family and friends. He was a member of the Dane County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association. Surviving are his widow, Ruth; two sons, Dr Carl Weston and John Weston of Madison; and four daughters, Jane Johnson, Rocky River, Ohio; Nan Thompson, Milwaukee; Sue Van Steenderen, Stoughton, and Mary Frautschi of Madison. ■

Dr Weston

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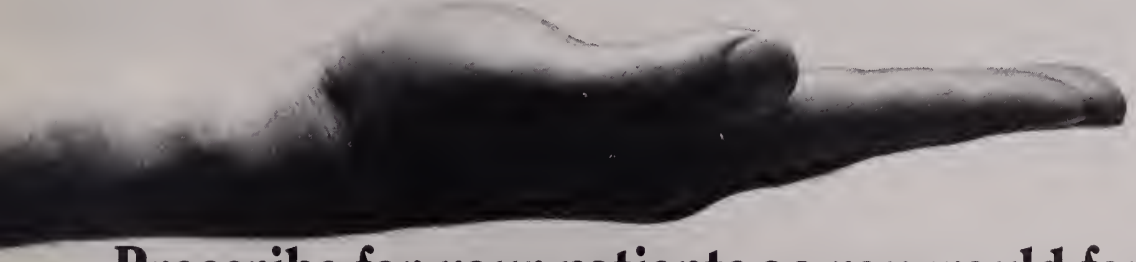

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Write "D.A.W.," "No Sub," or "Medically Necessary," as your state requires, to make sure your patient receives the original allopurinol.

Wellcome / **Burroughs Wellcome Co.**
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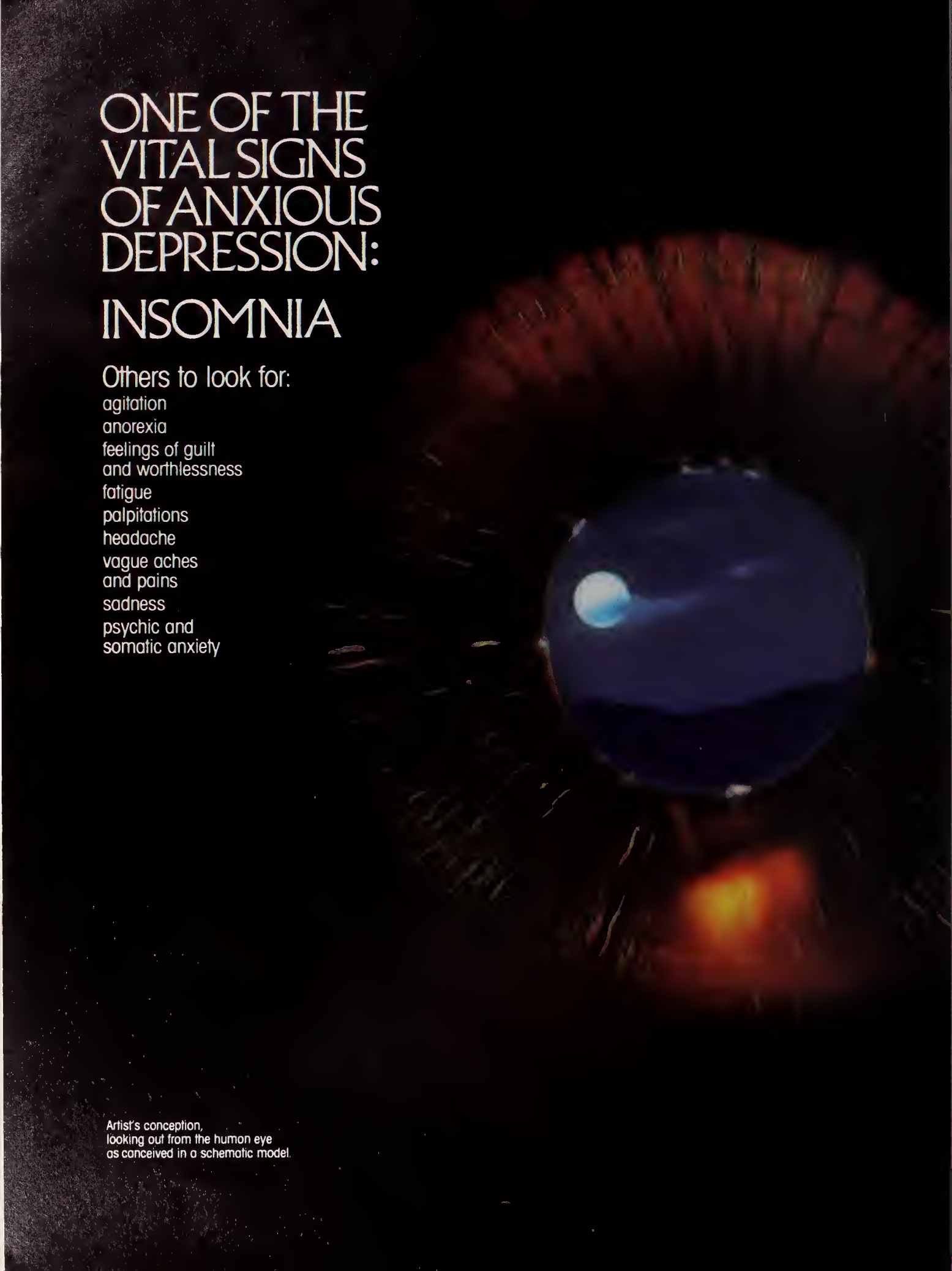
ONE OF THE VITAL SIGNS OF ANXIOUS DEPRESSION:

INSOMNIA

Others to look for:

agitation
anorexia
feelings of guilt and worthlessness
fatigue
palpitations
headache
vague aches and pains
sadness
psychic and somatic anxiety



Artist's conception, looking out from the human eye as conceived in a schematic model.

ROCHE

LIMBITROL GIVEN H.S.: ONE OF THE VITAL SPECIFICS OF TREATMENT

Limbitrol brings a special—and specific—quality of relief to most anxious depressed patients. Insomnia, for example, responds with particular promptness. Other symptoms likely to respond within the first week of treatment include anorexia, agitation and psychic and somatic anxiety. And, as the depression and anxiety are alleviated, in many cases so are such related somatic symptoms as headache, palpitations, and various vague aches and pains.

Limbitrol given once daily h.s. may be the best approach

Many patients respond readily to a single bedtime dose of Limbitrol, a convenient schedule that may enhance compliance and helps relieve the insomnia associated with anxious depression. Limbitrol also offers a choice of other regimens: t.i.d., or a divided dose with the larger portion h.s. In all cases, caution patients about the combined effects with alcohol or other CNS depressants and about activities requiring complete mental alertness, such as driving or operating machinery.

in moderate depression and anxiety

Limbitrol® IV

Tablets 5-12.5 each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)
Tablets 10-25 each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt)

Specific therapy with h.s. dosage convenience

Please see summary of complete product information on following page.

LIMBITROL® TABLETS Tranquilizer—Antidepressant
Before prescribing, please consult complete product information, a summary of which follows:
Indications: Relief of moderate to severe depression associated with moderate to severe anxiety
Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use, then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.
Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).
Usage in Pregnancy: **Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).
Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.
Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.
The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:
Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.
Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.
Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.
Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.
Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.
Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.
Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.
Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels.
Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.
Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.
Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly. Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased to six tablets or decreased to two tablets daily as required. Limbitrol 5-12.5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses.
How Supplied: White, film-coated tablets, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500, Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10, Prescription Paks of 50.

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Manati, Puerto Rico 00701

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Medical Yellow Pages

RATES: 40¢ per word, with a minimum charge of $16.00 per ad. BOXED AD RATES: $32.00 per column inch. DEADLINE: Copy must be received by the 20th of the month preceding month of issue; e.g., copy for the August issue is due July 20. Send copy to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 800/362-9080.

Physicians Exchange

Obstetrics-Gynecology. Position available at the Racine Medical Clinic, a progressive cluster corporation of 25 physicians. Excellent benefits, unlimited earnings and a fulfilling practice offered. Please contact: Roger D Lacock, Administrator, Racine Medical Clinic, 5625 Washington Ave, Racine, Wis 53406; ph 414/886-5000. 9tfn/82

Family Physician or Internist with family practice interest to join physician in well established practice in southeastern Wisconsin. Excellent hospital with specialty consultants available. Educational and recreational facilities abundant in area. Opportunity for immediate substantial income, early corporation membership and eventual purchase of practice to qualified individual. Contact Dept 510 in care of the Journal. 10-12/82

Chief Medical Officer for Department of Corrections in Missouri. Administrative work combined with medical duties. Stable employment in a middle-class city. Immediate opening. Contact: Melvin Gardner, Personnel Officer, PO Box 236, Jefferson City, Missouri 65102. 10/82

Locum tenens services. Wisconsin-licensed family physician available and also needed. Our physicians do office, hospital, emergency room and OB work. Call or write: INTERHEALTH, 5695 Merry Lane, Excelsior, MN 55331; ph 612/474-4372. 10-12/82;1-4/83

Family Practice opportunity available to join a long-established, four-physician family practice group in south central Wisconsin. Salary basis initially, leading to full corporate membership. Numerous fringe benefits. Pleasant community. Contact: Chad Burchardt, Business Manager, Medical Associates of Beaver Dam, SC, 1200 N Center St, Beaver Dam, Wis 53916; ph 414/887-7101. 10-12/82

Okauchee, Wis. Thirty miles west of Milwaukee. An attractive lake community needs professional services. Our growing population supports one public and two private grade schools. Our community presents an excellent opportunity for a physician to build a rewarding practice. If you are interested, write to: Okauchee Area Business Association, PO Box 35, Okauchee, Wis 53069. 10-12/82

PUT EXPERIENCE TO WORK FOR YOU WHILE YOU SEARCH FOR A NEW CHALLENGE

Let years of experience as a healthcare professional and a Placement Counselor assist you in finding a new location with a new challenge. Physicians in all specialties are urgently needed throughout the country. Many types of situations available. Confidentiality assured.

Contact Donna Herschleb, RN
MEDICAL PROFESSIONAL PLACEMENTS
5222 Painted Post Drive, Madison, Wisconsin 53716
Phone: (608) 222-2927 *Licensed Employment Agency*

Plastic Surgeon and Dermatologist positions available with an 18 member multispecialty group corporate practice. Modern clinic facility in Northeastern Wisconsin city of 100,000 enjoying a healthy and stable economy. Excellent recreational, educational, hospital, civic advantages. Please call collect or write: W J Mommaerts, Clinic Manager, West Side Clinic, sc, 1551 Dousman St, Green Bay, Wis 54303; ph 414/494-5611. 9-12/82

Obstetrician/Gynecologist to join well established general surgeon. On-call coverage malpractice and other expenses paid. Clinic one block from hospital. Superb hunting, fishing, and skiing facilities within a mile area. Initial salary with excellent fringe benefits including pension and profit sharing plan. Option to buy in practice later on. Position available immediately. Contact Dept 505 in care of the Journal. 9-10/82

Family physician and physicians from other specialties to join Board certified surgeon. Clinic within a block from hospital. No initial expense. Fully paid malpractice and health insurance. Salary with excellent fringe benefits. Option to buy in practice later on. Position available immediately. Contact Dept 507 in care of the Journal. 9-10/82

OB/GYN Specialists. Enjoy the security of group practice with the freedom of independent practice. If you are Board certified or Board eligible in OB/GYN, we have an interesting opportunity for you. Two specialists are needed immediately to form an independent OB/GYN practice in a very desirable Northern Wisconsin community with a drawing population of 70,000. Active practice assured. All major specialists available for consultation. Business and technical advice will be provided. Outstanding personal benefit programs available. Good income potential. New 35 million dollar hospital. For further information write: Administrator, PO Box 1646, Wausau, Wisconsin 54401. 9-11/82

Pediatric, Family Practice positions available in 13-member multispecialty group. Inquire: General Clinic of West Bend, Inc, 279 S 17th Ave, West Bend, Wis 53095. 2tfn/82

Urgently needed. Family Practice physician needed immediately. Board certified or Board eligible. Established family practice multispecialty clinic. Competitive salary first year, followed by equal partnership. Fringe benefits including paid malpractice, meeting and vacation time. Call: Gary Quammen, Clinic Manager 715/748-2121; or send CV to: The Medford Clinic, 101 N Gibson Ave, Medford, Wis 54451. p10/82

PRIMARY CARE PHYSICIANS
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We represent over 50 communities throughout the state which are seeking quality primary care physicians. These communities offer established service areas, generous practice and financial arrangements.

CONTACT:
Laurie Glowac or Fred Moskol
New Physicians for Wisconsin
University of Wisconsin Department of Family Medicine
777 South Mills Street, Madison, Wisconsin 53715
Phone: 608/263-4095

1-12/82

Physicians Exchange

continued

Doctors needed—in Wisconsin. All specialties and all locations. For confidential information, mail your CV to: Medicus, 1525 Wisconsin Ave, Grafton, WI 53024. 6tfn/82

Wausau Medical Center, SC, a 50-physician multispecialty group has openings for physicians in the following specialties: *OB/GYN, Otolaryngology, Cardiology, Neuroradiology,* and *General Surgery.* Competitive first-year salary, incentive plan thereafter. Comprehensive fringe benefits. New facility near new hospital. Located in beautiful, quiet, central Wisconsin, metropolitan area of 65,000. Recreational opportunities abundant. For more information contact: K L Day, MD, Wausau Medical Center, SC, 2727 Plaza Drive, Wausau, Wis 54401, or call collect 715/847-3351. 6tfn/82

Family Practice position available with an 18-member multispecialty group corporate practice. Modern clinic facility in Northeastern Wisconsin city of 100,000 enjoying a healthy and stable economy. Excellent recreational, educational, hospital, civic advantages. Please call collect or write: W J Mommaerts, Clinic Manager, West Side Clinic, SC, 1551 Dousman St, Green Bay, Wis 54303; ph 414/494-5611. 8-11/82

Family Physician to join three Board certified family physicians in a young and growing medical practice in Central Minnesota. The practice is orientated toward Family Practice Medicine and located centrally in the state with quick access to the Minneapolis-St Paul area. Both practices are a short distance from the St Cloud area, and our physicians use the St Cloud Hospital for hospitalization of their patients. Cultural and recreational activities are abundant in this area of Minnesota. The salary and fringe benefits are open and negotiable. If interested, please contact Thomas J Newton, MD, Medical Director, or contact Daryl G Mathews, Administrator, at either the St Joseph or Cold Spring Medical Clinics, 26 North Red River Ave, Cold Spring, Minnesota 56320; or call collect (612) 685-8641 or (612) 363-7765 in St Joseph, Minnesota. 7-10/82

Anesthesiologist, Wisconsin-born. Graduate University of Wisconsin Medical School, 1980. Currently training in New England desires practice in Wisconsin. Trained in all types of anesthesia. Available August 1983. Contact Dept 506 in care of the Journal. 8-10/82

Family Practitioner and occupational medicine specialist needed to join multispecialty group of 33 physicians dedicated to primary care in East Central Wisconsin community. City population 38,000, drawing area 100,000. Attractive income arrangements, association membership possible after one year, pension and profit sharing, extensive fringe benefits. Contact R B Windsor, MD, 1011 North 8th St, Sheboygan Wis 53081; ph 414/457-4461 10tfn/82

U S Air Force Medical Corps currently is accepting applications for physicians in the following specialties: *Surgery (all specialties), Obstetrics/Gynecology, Otorhinolaryngology, Anesthesiology, Urology, Rheumatology, Neurology, Psychiatry.* For further information call collect, MSGT Charles Brown Jr, 414/258-2480. 10/82

Family Physician for Locum Tenens. Experienced Board certified family physician for 9 years on the full time faculty of the University of Wisconsin Medical School, available for Locum Tenens, all areas of Wisconsin. Contact: Rudolph C Hecht, MD, 312 Newcastle Way, Madison, Wis 53704; ph (home) 608/249-5201. 10-12/82

Locum Tenens opportunity available 9/30/82. Temporary full time position to carry patient load of exiting physician. Potential for permanent practice if desired. Excellent pay arrangements and liability insurance. If interested please contact: Norman C Schroeder, MD, Park Medical Center, Ltd, 601 North 8th St, Manitowoc, Wis 54420; ph 414/682-4646. 9-11/82

Family Practice Physician to share fully equipped medical office in central Wisconsin city. Opportunity for partnership and eventual purchase of practice. Excellent recreational, educational, hospital, and civic advantages. Send curriculum vitae to Dept 503 in care of the Journal. 6tfn/82

Family Physician to join our group of six Board certified family practitioners and Board certified general surgeon. Liberal vacation and educational allowances. Competitive salary first year with incentive bonus, and full membership after one year. Blue Earth is a farming town of 4000 in Southern Minnesota with a drawing area of 25,000. 35-bed hospital with adjoining clinic facilities. Complete opportunity for an aggressive young family physician. Please contact Marjeane Werner or Thomas E Watts, MD, Blue Earth Medical Center, Ltd, 520 South Galbraith, Blue Earth, Minn 56013; ph 507/526-7371. 8-12/82; 1/83

Adult Psychiatrist to join well established group in a community of 50,000 with large referral area. Two excellent hospitals, University, and industrial area. Salary—open. Excellent benefits. For further information contact: J M Tobin, MD, Northwest Psychiatric Clinic, Eau Claire, Wis 54702; ph 715/834-2751. 8-12/82; 1/83

The Racine Medical Clinic, a progressive cluster corporation of 25 physicians, is currently seeking an orthopedic surgeon and an invasive cardiologist. Full benefits, unlimited earnings and a full and exciting practice are offered. Please contact: Roger D Lacock, Administrator, Racine Medical Clinic, 5625 Washington Ave, Racine, WI 53406; ph 414/886-5000. 1tfn/82

Internist wanted. Board certified or eligible with/without subspecialty, to practice in conjunction with a 6-member Internal Medicine Department in a 22-member multispecialty group. Present subspecialties: Gastroenterology and cardiology. The group is in Southeastern Wisconsin, in a city of 100,000 between two major metropolitan areas of greater than one million. If interested, please send CV to: Stephen L Wagner, Kurten Medical Group, 2405 Northwestern Ave, Racine, Wis 53404. All inquiries will be kept confidential. 3tfn/82

Family Practice Physician/or Primary Care Oriented Internist to join two family practice physicians and a Board certified surgeon in a group practice. Located in a community of 2,500 in southwest Minnesota. This medical clinic is supported by a modern 30-bed acute care hospital and 138-bed skilled long-term care facility. Guaranteed first year income, will pay travel expenses for interview. Interested physicians send curriculum vitae to William Wilson, Administrator, Springfield Community Hospital, PO Box 146, Springfield, Minn 56087 or call collect 507/723-4215 for more information. 5-10/82

Surgeon with general vascular training, Ophthalmologist, and ENT, to join a progressive multispecialty group of 17 physicians consisting of General/Family Medicine, General Surgery, Internal Medicine, OB-GYN, Ophthalmology, Orthopaedic Surgeon, Pediatrics/Adolescent Medicine, and Radiology. Subspecialties include: Pathology, Vascular Surgery, Cardiovascular Diseases, Gastroenterology and Endoscopy. We are located in a fast growing, scenic, lake country area between Milwaukee and Madison and can offer excellent hospital, schools, and recreational facilities. Full fringe benefit package. Contact: James F Dowd, Admin, Wilkinson Clinic SC, 915 East Summit Ave, Oconomowoc, Wis 53066; ph 414/567-4433. 10tfn/82

Family Practice/Urgent Care position immediately available in a 42-member multispecialty group corporate practice to direct and operate evening and weekend Urgent Care facility. Beautiful clinical facility in Glendale, Wisconsin, a northern Milwaukee suburban city. Guaranteed first-year salary, stockholdership and partnership after one year, plus profit-sharing. To learn more about our opportunity and to receive our immediate consideration, please submit your CV to Mr James A Heinz, Assistant Administrator, Milwaukee Medical Clinic, SC, 3003 West Good Hope Rd, PO Box 17300, Milwaukee, Wis 53217. 8-10/82

Family Physician or Internist to join three-man family and general practice group in the heart of North Central Wisconsin vacationland. First year guaranteed salary. Numerous fringe benefits. Clinic across from hospital. Send CV to: O M Francisco, MD, 221 E Washington Ave, Tomahawk, Wis 54487; ph 715/453-2147. 5tfn/82

Wanted. Board certified or eligible orthopedic surgeon to practice in conjunction with a 5-member surgery department in a 22-member multispecialty group. Present surgical specialties: thoracic and vascular surgery, general surgery and urology. The group is located in the upper midwest, in a city of 100,000 between two major metropolitan areas of greater than one million. If interested, please send CV to: Stephen Wagner, Kurten Medical Group, SC, 2405 Northwestern Ave, Racine, Wis 53404. All inquiries will be kept confidential. 12tfn/80

Wanted. An internist interested in cardiology, an orthopedist and a psychiatrist. Work part-time (20-35 hours/week) at the Bureau of Social Security Disability Insurance, 310 Price Place, Madison, Wisconsin 53705. If interested, please write or telephone George H Handy, MD, PO Box 7623, Madison Wis 53707; ph 608/266-1989. 10-12/82

Excellent opportunity to practice general internal medicine and/or gastroenterology by assuming part of a retiring physician's practice in a 4-man group. Salary negotiable. Excellent fringe benefits. Send CV to Administrator, Cathedral Square Medical, 525 E Wells, Milwaukee, Wisconsin 53202. 10-11/82

Ideal practice opportunities for Family Practice and Internal Medicine in scenic Kettle Moraine area, Plymouth, Wisconsin. Less than one hour drive from Milwaukee, 60 miles from Green Bay. Service community of 20,000. Modern JCAH hospital and 60-bed nursing home. Family-oriented community with good industrial base. Please contact: Peter R Strub, Coordinator, Physician Recruitment Committee, Plymouth Hospital, Inc, 901 Reed St, Plymouth, Wis 53703; ph 414/893-1771. 8/82*

Medical Facilities

Family Practice and Clinic Building in Spring Valley, Wisconsin, (town is 45 minutes drive to St Paul; one hour to Minneapolis). Building with 3 examining rooms, x-ray room with equipment, laboratory, coffee room, waiting room, and a doctor's office. Sales include all furniture, equipment, supplies, 2 refrigerators. Big lot with parking area for doctors and many cars. Available immediately. All these for $89,000. Should see to appreciate. Please call 715/778-5591 (5:30 pm to 7:30 pm); 715/778-4415 after 7:30 pm and week-ends. 9-11/82

Established solo practice in internal medicine for sale. Available immediately. Located in Milwaukee area. For information call 414/332-9006 or contact Dept 509 in care of the Journal. g9/82

Space sharing opportunity. Enjoy your independent practice in a fully equipped/fully staffed new medical facility in Waukesha, Wisconsin. Rapidly expanding area. Located just six minutes from two excellent hospitals. Arrangements open. Contact Westmound Medical Clinic; ph 414/549-9100. 9-10/82

Medical office space for lease. New Swiss chalet style building in fast growing community. Needs family practitioner, pediatrician, etc. Building has dentist and pharmacy. Very reasonably priced in Waukesha County near expressway. Info: call 414/781-1155. 7tfn/82

Office furniture for sale. Metal desk and credenza. One swivel and two contemporary chairs with floor lamp. Call 414/332-4241 after 4:00 pm. g10tfn/82

Two-story medical office building for sale, New London, Wis, for single or group practice. Fully equipped and ready for occupancy Nov 1, 1982. Reason for vacancy—physician retiring from very active 50-year practice. First floor includes four examining rooms, lab and x-ray facilities, large waiting room, and bookkeeping office. Call 414/982-2144 Monday through Thursday; 414/982-3615, evenings and weekend. 10-12/82

Miscellaneous

Physicians Signature Loans to $50,000. Up to 7 years to repay. No prepayment penalties. Prompt, courteous service. Physicians Service Assn, Atlanta, GA. Toll-Free (800) 241/6905. 4tfn/82*

Firewood, mixed hardwoods and oak, free delivery anywhere in Wisconsin, Illinois, Michigan. $50 face cord, 10-cord minimum. If too much, share with a friend. Order for delivery now or later. Call collect 715/854-2393 anytime. 10/82

Allied Health Services

Physician Assistant. Recent honors graduate of UW-Madison seeks employment. Dependable, hardworking. Resumes and references furnished upon request. Contact Jim Kearin, 2822 Union St., Madison, Wis 53704; ph 608/249-1417. p10/82

Real Estate

A SAFE TAX SHELTER. Land ownership offers more. The new A.C.R.S. (Accelerated Cost Recovery System). Depreciation + Inflationary Appreciation + Investment Credits, all put money into your pocket. FAITH REALTY—Est 1960, Farm Specialist-Tax Consultant, Whitewater, Wis 53190 (414/473-2779). PS: Who do you know who wants to buy a farm? 9-12/82; 1-2/83

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Meetings/CME Courses

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates: 40¢ per word, with a minimum charge of $16.00 per listing. BOXED LISTINGS: $32.00 per column inch. COPY DEADLINE for Continuing Medical Education listings is tenth of the month preceding the month of publication; e.g., copy for the August issue is due by July 10. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 800/362-9080. For listing of other meetings see the Special issue of the Journal of the American Medical Association: Continuing Education Courses for Physicians for period Sept 1, 1982 through Aug 31, 1983.

WISCONSIN

OCTOBER 24-26, 1982: *Eighth Annual Fall CME Seminar,* The Wisconsin Academy of Physicians' Assistants, at Fox Hills Resort, Mishicot. Approved for 14 Category 1 WAPA hours; approved for 14 elective credit hours of the AAFP; applied for 14 Category I hours of AAPA. Info: WAPA, PO Box 1109, Madison, Wis 53701.

OCTOBER 25-27, 1982: *Advances in Diagnostic Ultrasound,* Madison. Sponsored by University of Wisconsin-Extension, Continuing Medical Education; and University of Wisconsin, School of Medicine, Department of Radiology. Twenty-one credit hours of AMA, ACR, University of Wisconsin CEU's. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

NOVEMBER 9, 1982: *25th Annual Clinic Day Program Diagnostic Advances in Radiology,* St Joseph's Hospital, Milwaukee. Approved four credit hours Category I CME/AAFP. Info: Medical Education Office, St Joseph's Hospital, 5000 W Chambers St, Milwaukee, Wis 53210.

NOVEMBER 9, 1982: *Suicide Assessment and Intervention,* Kenosha. Sponsored by University of Wisconsin-Extension, Dept of Allied Health and University of Wisconsin-Extension, Dept of Mental Health. AMA Category I, 6 hours; University of Wisconsin-Extension Continuing Education Hours, 6 hours. Info Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

NOVEMBER 10, 1982: *Maintaining the Chronically Mentally Ill in the Community*—the Nurse's Role, presented by Staff of the Mendota Mental Health Institute's Program for Assertive Community Treatment (PACT). Contact Training Dept, MMHI, 301 Troy Drive, Madison, Wis 53704; phone 608/244-2411.

NOVEMBER 13-14, 1982: *Therapeutics 1982,* Madison. Sponsored by University of Wisconsin-Extension, Dept of Continuing Medical Education; and University of Wisconsin School of Medicine, Dept of Medicine. Credit: University of Wisconsin-Extension CEU's, AMA Category 1, AAFP and AOA approved for—all 9 hours. Info: Sarah Z Aslakson, Continuing Medical Education, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

NOVEMBER 16, 1982: *Family Therapy with Troubled Adolescents,* presented by Larry Kogan, Family Treatment Unit, St Louis County Juvenile Court, at Mendota Mental Health Institute in Madison. Contact Training Dept, MMHI, 301 Troy Drive, Madison, Wis 53704; phone 608/244-2411.

NOVEMBER 18, 1982: *Alcoholism Update; A Problem-Solving Seminar for Physicians,* Sentry Insurance Headquarters, Stevens Point. Sponsored by The Committee on Alcoholism and Other Drug Abuse, State Medical Society of Wisconsin. (See further details elsewhere in this section)

NOVEMBER 19, 1982: *Working with the Person with Organic Brain Syndrome,* presented by Mendota Mental Health Institute Staff. Contact Training Dept, MMHI, 301 Troy Drive, Madison, Wis 53704; phone 608/244-2411.

DECEMBER 3, 1982: *Obsessive/Compulsive Neurosis & Phobic Reactions,* at Mendota Mental Health Institute, Madison. Presented by Harold Esler, PhD and Irene Sarkissian, RN, MA, Midwest Psychoanalytic Institute. Contact Training Dept, Mendota Mental Health Institute, 301 Troy Drive, Madison, Wis 53704; phone 608/244-2411.

DECEMBER 3-4, 1982: *2nd Annual Coronary Artery Disease Update,* Madison. Sponsored by University of Wisconsin School of Medicine, Dept of Medicine, Division of Cardiology and Departments of Surgery, Division of Thoracic and Cardiovascular Surgery; and University of Wisconsin-Extension, Dept of Continuing Medical Education. AMA Category 1; AOA Category 2-D, AAFP, University of Wisconsin CEU's. Info: Sarah Z Aslakson CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

DECEMBER 4, 1982: *Wisconsin Chapter, American College of Surgeons,* Hyatt Regency, Milwaukee.

DECEMBER 10, 1982: *Working with the Aggressive Elderly Person,* at Mendota Mental Health Institute, Madison. Contact Training Dept, Mendota Mental Health Institute, 301 Troy Drive, Madison, Wis 53704; phone 608/244-2411.

STATE MEDICAL SOCIETY OF WISCONSIN
Dates and Locations of Annual Meetings
1982-1992

All meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) and the new Hyatt Regency as the headquarters hotel with the exception of 1985, when the meeting will be held at the LaCrosse Convention Center.

1983—Mar 24-26	**1988—Apr 28-30**
1984—Mar 29-31	**1989—Apr 13-15**
1985—Apr 25-27	**1990—Apr 26-28**
1986—Apr 17-19	**1991—Apr 18-20**
1987—Mar 26-28	**1992—Apr 23-25**

Meeting days will be Thursday and Friday; the first session of the House of Delegates will convene on Thursday, the second and third on Friday. Scientific programming will be on Friday and Saturday.

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701. Local telephone: 257-6781; toll-free in Wisconsin: 1-800/362-9080.

JANUARY 12-14, 1983: *Clinical Cancer Conference,* The Telemark Lodge, Cable. Sponsored by Marshfield Clinic, Duluth Clinic, Wisconsin Cancer Society and the Minnesota Cancer Society. Info: Office of Medical Education, 1000 North Oak Ave, Marshfield, Wis 54449; ph 715/387-5207.

JANUARY 17-19, 1983: *New Therapeutics III: The Results of Recent Advances in Medicine,* at Telemark Lodge, Cable. Sponsored by University of Wisconsin School of Medicine and University of Wisconsin–Extension, Department of Continuing Medical Education. Approved 14 credit hours of Category I of AMA/AAFP; 1.4 CEUs UW–Extension Continuing Education Units. Fee: $235. Info: Ann Bailey, Administrator, CME, 454 WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2854.

FEBRUARY 16-18, 1983: *Medical/Surgical Update '83.* The Telemark Lodge, Cable. Sponsored by Marshfield Clinic. Info: Office of Medical Education, 1000 North Oak Ave, Marshfield, Wis 54449; ph 715/387-5207.

FEBRUARY 19, 1983: Wisconsin Dermatological Society, University Hospitals, Madison.

MARCH 10-11, 1983: *8th Annual Ophthalmology Current Concepts Seminar '83,* at Concourse Hotel, Madison. Sponsored by University of Wisconsin School of Medicine, Department of Ophthalmology; and University of Wisconsin–Extension, Department of Continuing Medical Education. AMA Category 1, University of Wisconsin Continuing Education Units. Info: Sarah Z Aslakson, CME, 465 B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

OTHERS

NOVEMBER 12, 1982 (New York): *Clinical Techniques for the Practice of Family Therapy,* Long Island Jewish-Hillside Medical Center. Sponsored by Dept of Psychiatry, Long Island Jewish-Hillside Medical Center. Approved 6 credit hours in Category 1 from ACCME and applies toward the American Psychiatric Association requirements. Info: Ann J Boehme, Continuing Education Coordinator, Long Island Jewish-Hillside Medical Center, New Hyde Park, NY 11042; ph 212/470-2114. 10/82

ALCOHOLISM UPDATE: A Problem-Solving Seminar for Physicians

Sponsored by
Committee on Alcoholism and Other Drug Abuse
State Medical Society of Wisconsin

November 18, 1982: Stevens Point

8:55 Welcome, *Michael Gordon, MD*
9:00 Pathophysiology of Alcoholism, *Herbert White, DO*
9:30 Disease Concept of Alcoholism, *Michael Gordon, MD*
10:00 Detox, *Craig Larson, MD*
10:45 Multiple Chemical Dependency, *Herbert White, DO*
11:15 Special Problems of the Alcoholic Woman, *Pauline Jackson, MD*
11:45 The Family Illness, *Michael Gordon, MD*
12:15 Luncheon Program: What Do Alcoholics Anonymous and Al-Anon Have to Offer?
1:15 Adolescent Chemical Dependency, *Roland E Herrington, MD*
1:45 Psychiatric Problems of Alcoholics, *Craig Larson, MD*
2:15 Medical-Legal Issues, *H B Maroney, JD*
3:00 Confrontation and Motivation to Seek Help, *Pauline Jackson, MD*
3:30 Treatment and Community Resources, *Herbert White, DO*
4:00 Some Do's and Don'ts, Panel Discussion

Approved 6 credit hours of Category 1 of AMA-PRA and AAFP. Fee: $55/member of SMS; $7.50 for resident; $80 for non-members.

Info: State Medical Society of Wisconsin, PO Box 1109, Madison, Wis 53701; or call Bill Wendle or Arlene Meyer, 1-800/362-9080 or 608/257-6781.

WISCONSIN SPECIALTY SOCIETY MEETINGS: 1982-1983

Wisconsin Radiological Society, Oct 16, 1982, Concourse Hotel, Madison

Wisconsin Orthopaedic Society, Nov 5, 1982, Olympia Resort, Oconomowoc

Wisconsin Allergy Society, Nov 6-7, 1982, Pioneer Inn, Oshkosh

Wisconsin Neurosurgical Society, Nov 5-6, 1982, Marriott Inn, Brookfield

Wisconsin Chapter: American College of Emergency Physicians, Oct 14-15, 1982, Midway Motor Lodge, Brookfield

Wisconsin Orthopaedic Society, Nov 5, 1982, Olympia Resort, Oconomowoc

Wisconsin Chapter: American College of Surgeons, Dec 4, 1982, Hyatt-Regency, Milwaukee

Wisconsin Chapter: American Academy of Pediatrics, May 19-20, 1983, Pioneer Inn, Oshkosh

Wisconsin Academy of Family Physicians, June 16-18, 1983, Lake Geneva

* * *

SPECIALTY SOCIETY MEETINGS TO BE HELD IN CONJUNCTION WITH SMS ANNUAL MEETING, March 24-26, 1983, Milwaukee

Wisconsin Allergy Society
Wisconsin Orthopaedic Society
Wisconsin Psychiatric Association
Wisconsin Society of Internal Medicine
Wisconsin Society of Pathologists
Wisconsin Society of Physical Medicine and Rehabilitation
Wisconsin Society of Plastic Surgeons
Wisconsin Society for Preventive Medicine
Wisconsin Society of Radiation Oncologists
Wisconsin Surgical Society

DECEMBER 8-10, 1982 (Illinois): *Neurology for the Non-Neurologist,* The Westin Hotel, Chicago. Sponsored by Rush-Presbyterian-St Luke's Medical Center. Approved 20 credit hours of Category 1 AMA-PRA. Info: University of Office of Continuing Education, Rush-Presbyterian-St Luke's Medical Center, 600 South Paulina, Chicago, IL 60612; ph 312/942-7095. 8-11/82

JANUARY 6-7, 1983 (Hawaii): *Regional Meeting, American College of Physicians,* Hilton Hawaiian Village, Honolulu. Info: Robert A Nordyke, FACP, 2013 Kakela Drive, Honolulu, HI 96822. g10/82

JANUARY 27-28, 1983 (Ontario): *Regional Meeting, American College of Physicians,* Mount Saint Marie, Quebec, ONT. Info: Robert Volpe, MD, FACP, Wellesley Hospital, 160 Wellesley St, E, Toronto, ONT M4Y 1J3. g10/82

FEBRUARY 7-11, 1983 (IDAHO): *Scientific/Ski Meeting:* 36th Annual Meeting of Northwestern Medical Association, Sun Valley, Idaho. Transplants-implants, general medicine subjects, ski-injury prevention, high-altitude physiology and financial planning will be discussed by experts. Approved 10 credits Category 1 ACCME. Registration, 3 to 5 pm on Feb 7, 1982, Challenger Inn, Sun Valley. Non-members registration/$100. Info: Norman Christensen, MD, 2456 Buhne St, Eureka, CA 95501; ph 707/443-2248. 9-10/82

MARCH 6-9, 1983 (MISSOURI): Sixth National Conference on Rural Primary Care, at Radisson-Muehlebach Hotel, Kansas City. Sponsored by National Rural Primary Care Association and cosponsored by over a dozen national health-related organizations. Hosted by American Academy of Family Physicians. Of interest to anyone involved in rural health care: administrators, physicians, nurses, NPs, PAs, health educators, health planners, students, consultants, etc. Info: Carrie Samuel, Conference Coordinator, NRPCA office, Box 1211, Waterville, ME 04901 (phone: 207/873-7784). g9-12/82;1/83

1983 CME Cruise/Conferences on Legal-Medical Issues—Caribbean, Mexican Riviera, Alaska, Mediterranean. 7-14 days in January, April, July, August. Seminars led by distinguished professors. Approved for 18-24 CME Category 1 credits. *Free Roundtrip Airfare on all Caribbean, Mexican, Alaskan Cruises.* Excellent group fares on finest ships. All conferences, scheduled prior to 12/31/80, conform to IRS tax deductibility requirements under 1976 Tax Reform Act. Registration limited. For color brochures and additional information contact: International Conferences, 189 Lodge Ave, Huntington Station, NY 11746; ph 516/549-0869. p9-10/82

AMA

DECEMBER 5-8, 1982: Interim AMA House of Delegates, Miami Beach, Fl.

JUNE 19-23, 1983: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 4-7, 1983: Interim AMA House of Delegates, Los Angeles, CA.

JUNE 17-21, 1984: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 5-7, 1984: Interim AMA House of Delegates, Honolulu, Hawaii. ■

Bookshelf

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School and by others who are particularly qualified. Most books here listed will be available on loan from the Medical Library Service, 1305 Linden Drive, Madison, Wisconsin 53706; tel. 608/262-6594.

Current Medical Diagnosis and Treatment, 1982. Edited by Marcus A Krupp, MD and Milton J Chatton, MD. 1982. Lange Medical Publications, Drawer L, Los Altos, Calif 94022. Pp 1111. Price: $23.00.

Current Pediatric Diagnosis & Treatment, 7th Edition. By C Henry Kempe, MD; Henry K Silver, MD; Donough O'Brien, MD, FRCP. 1982. Lange Medical Publications, Drawer L, Los Altos, Calif 94022. Pp 1106. Price: $26.00.

Physician's Handbook, 20th edition. By Marcus A Krupp, MD; Lawrence M Tierney Jr, MD; Ernest Jawetz, MD, PhD; Robert L Roe, MD; Carlos A Camargo, MD. 1982. Lange Medical Publications, Drawer L, Los Altos, Calif 94022. Pp 774. Price: $12.00.

Evaluation of Paramedic Services for Cardiac Arrest. NCHSR Report Series. 1981. US Dept of Health and Human Services, Office of Health Statistics, and Technology, National Center for Health Services Research, 3700 E-West Highway, Hyattsville, MD 20782. Pp 71.

Sins of Commission. By Harold L Klawans, MD. 1982. Contemporary Books, Inc, 180 North Michigan Ave, Chicago, Ill 60601. Pp 340. Price: $13.95.

Medico-Legal Implications of Death and Dying. By David W Meyers. 1982. Bancroft-Whitney Company, 301 Brannan St, San Francisco, CA 94107 and The Lawyers Co-operative Publishing Co, Rochester, NY 14694. Pp 639.

The Healthiest City: Milwaukee and the Politics of Health Reform. By Judith Walzer Leavitt. 1982. Princeton University Press, 41 William-St, Princeton, New Jersey 08540. Pp 294. Price: $22.50.

Review of Medical Microbiology, 15th edition. By E Jawetz, MD, PhD; Joseph L Melnick, PhD; and Edward A Adelberg, PhD. 1982. Lange Medical Publications, Drawer L, Los Altos, CA 94022. Pp 553. Price: $17.00.

Medical Practice Management Desk Book. By Charles H Walsh and Morton Walker. 1982. Prentice-Hall, Inc, Englewood Cliffs, NJ 07632. Pp 208. Price: $39.50.

Vitamin C in Health and Disease, American Edition. By T K Basu and C J Schorah. 1982. Avi Publishing Company, Inc, 250 Post Road East, PO Box 831, Westport, Conn 06881. Pp 152. Price: $19.50.

Diagnosis Related Groups: A Practitioner's Guide. By Paul L Grimaldi and Julie A Micheletti. 1982. Pluribus Press, 160 E Illinois St, Chicago, IL 60611. Pp 296. Price: $24.95.

The American Medical Association Book of Woman Care. By Linda Hughey Holt and Melva Weber. 1982. Random House, Inc, New York, NY 10022. Pp 263. $12.95.

The American Medical Association Book of Heart Care. By Douglas Gasner and Elliott H McCleary. 1982. Random House, Inc, New York, NY 10022. Pp 220. $12.95. ■

PRACTICE MANAGEMENT COURSES

Marketing strategies for private practice. A new workshop for physicians offered by AMA at its headquarters in Chicago, November 5, December 10, 1982 and January 28, 1983. Session includes an update on major health care trends, improving referral patterns, enhancing patient satisfaction, and development of a coordinated marketing plan for solo physicians and small groups. Fees are $150 for members and $185 for nonmembers. Sessions limited to 30 registrants. Contact Dept of Practice Management, AMA Headquarters, 535 North Dearborn St, Chicago, Ill 60610; phone 312/751-6000; for brochure describing course. g10-12/82

PLACEMENT SERVICES

Opportunity Placement Register and **Physician Placement Register.** August/September issues now available from the AMA. The OPR contains hundreds of medical practice openings throughout the US. The PPR lists physicians seeking practice locations. Also available is a brochure, *Preparing a Professional Vitae*, designed to aid physicians in resume writing. To get a complimentary copy of any of these publications, write Physicians' Placement Service, AMA Headquarters, 535 North Dearborn St, Chicago, Ill 60610, or phone 312/751-6282. g10tfn/82

PUBLICATIONS

Lithium and Manic Depression: A Guide. A new publication now available from the Lithium Information Center. The guide, written by John Bohn, R Ph and James Jefferson, MD, with assistance from other staff members at the center, addresses the questions that are most frequently asked by patients and their families about lithium and its use in treating manic depression.

The 30-page guide serves as a general reference tool and a helpful consumer guide both for those taking lithium and for their families. ***$3.00/copy (1-10 copies); $2.00/copy (more than 10 copies); large bulk purchase prices available on request.*** If interested in purchasing one or more copies of this publication, send correct payment to: Lithium Information Center, Department of Psychiatry, University of Wisconsin-Madison, 600 Highland Ave, Madison, WI 53792.

ANNOUNCEMENTS

Socioeconomic Monitoring System. The AMA has launched a speedier method of gathering and reporting changes in many aspects of physicians' practices. The system substitutes periodic telephone interviews with randomly selected physicians for annual mail questionnaires, the principal device used to gather socioeconomic information since 1966. The new system will yield information in about ten weeks instead of the 12 months required to gather and analyze mail survey forms. It will provide the AMA with the capability to update socioeconomic data on quarterly basis. Survey results will be widely disseminated. The program is directed by the AMA Center for Health Policy Research in cooperation with the AMA Division of Survey and Data Resources. Mathematica Policy Research, Inc of Princeton, NJ, will conduct the telephone interviews for the AMA. ■

Contributions to the

CES Foundation

of the State Medical Society of Wisconsin

provide support to the following:

- **Student loans**
- **Charitable assistance**
- **Medical student externship program**
- **Research activity**
- **Continuing medical education**

CONTRIBUTIONS ARE TAX DEDUCTIBLE
Checks should be made payable to: CES Foundation, and sent to CESF, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701.

U.S. Postal Service STATEMENT OF OWNERSHIP, MANAGEMENT AND CIRCULATION of the *Wisconsin Medical Journal*, issued monthly.

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OWNER: Same as publisher above.

KNOWN BONDHOLDERS, MORTGAGEES, AND OTHER SECURITY HOLDERS OWNING OR HOLDING 1 PERCENT OR MORE OF TOTAL AMOUNT OF BONDS, MORTGAGES OR OTHER SECURITIES: None.

THE PURPOSE, FUNCTION, AND NONPROFIT STATUS OF THIS ORGANIZATION AND THE EXEMPT STATUS FOR FEDERAL INCOME TAX PURPOSES have not changed during the preceding 12 months.

EXTENT AND NATURE OF CIRCULATION

	AVERAGE NUMBER COPIES EACH ISSUE DURING PRECEDING 12 MONTHS	ACTUAL NUMBER OF COPIES OF SINGLE ISSUE PUBLISHED NEAREST TO FILING DATE
Total number copies printed (net press run)	6035	6200
Paid circulation (mail subscriptions)	5756	5886
Total paid circulation	5756	5886
Free distribution by mail, carrier or other means (samples, complimentary, and other free copies)	181	177
Total distribution	5937	6063
Office use, left-over, unaccounted spoiled after printing	98	137
TOTAL	6035	6200

I certify that the statements made by me are correct and complete.
/s/ MARY ANGELL
Managing Editor

Date of filing: Sept 16, 1982
PS Form 3526, modified above for purposes of printing.

News You Can Use

By EARL THAYER, Secretary/BERNIE MARONEY, Assistant Secretary

NEW LAW AFFECTS RESIDENT STATUS OF FOREIGN MDs. Foreign physicians who entered the United States before 1978 may seek immediate status as permanent residents if they were fully licensed and practiced medicine in this country on or before January 9, 1978 due to a new law (Public Law 97-81) passed by Congress during the current legislative session. SMS, working with Doctors Arturo C Sapida of Lake Geneva and Juanito P Singson of Milwaukee, both of the Phillipine Medical Association, personally met with members of the Wisconsin Congressional delegation seeking passage of the bill.

AMA EVP SAMMONS TO SPEAK AT NOVEMBER 12-13 LEADERSHIP CONFERENCE. The 1982 SMS Leadership Conference, set for November 12-13 at the Brookfield Marriott, Milwaukee, will be highlighted by an appearance by James H Sammons, MD, executive vice president of the American Medical Association. Doctor Sammons will close the meeting Saturday, November 13, with a luncheon address. The State Medical Society has been holding leadership conferences in recent years to bring together SMS directors and officers, county medical society and specialty society presidents, committee/commission chairpersons, and AMA delegates and alternates to explore current and future trends in medicine and health care and to define the Society's role in these issues. This year's meeting will feature presentations on: "What's Ahead in the New Biennium (SMS proposals for legislation, Medicaid, deregulation)"; "Is National Health Insurance Inevitable?"; "Preview of Post-Moratorium Plans"; "Ethically, Society Expects More From Physicians"; "The Three C's—Competition, Costs and FT"; "Is There Peer Review After PSRO"; "Tough Talk About Protecting Doctors (The best protection in your practice is a good medical record)". A program with registration details was mailed earlier this month to the above mentioned groups of physicians. Other interested physicians are also welcome to attend; please contact the SMS Secretary's office (257-6781 or 800-362-9080) for a copy of the program and registration form.

PATIENT MEDICATION INSTRUCTION PROGRAM BEGINS. The American Medical Association in September launched its Patient Medication Instruction (PMI) program by mailing copies of PMI program kits to over 387,000 medical doctors throughout the US. The purpose of the program is to provide supplementary written instructions on drugs to physicians for distribution to their patients. It is expected that the program will improve the effectiveness of therapy, reduce the risk of improper drug use, decrease the incidence of preventable and serious adverse drug reactions, and aid in patient compliance. The information is intended to augment the oral communications on drug therapy that takes place between physician and patient at the time a particular medication is being considered. The 5½" x 8½" information sheets are available in pads of 100. They must be ordered in quantities of ten or more and cost $.50 per pad (to cover handling and postage charges). PMIs currently are available on the following drugs: Furosemide, Thiazide Diuretics, Penicillins—Oral, Beta-Blockers, Digitalis Preparations, Coumarin-Type Anticoagulants, Oral Antidiabetics, Tetracyclines, Cephalosporins, Erythromycin, Nonsteroidal Anti-Inflammatory Agents, Benzodiazepines, Nitroglycerin, Methyldopa, Insulin, Corticosteroids—Oral, Cimetidine, Belladonna Alkaloids and Barbiturates, Phenytoin, and Sulfonamides.

PHYSICIANS WHO DISPENSE SUBJECT OF PACKAGING STANDARDS. Physicians who dispense drugs are subject to child protection packaging standards of the Poison Prevention Packaging Act in the same manner as pharmacists who dispense drugs, reminds the US Consumer Product Safety Commission. Therefore, a physician is responsible under the law for dispensing prescription drugs in child-resistant packaging. According to the Commission, the law does provide that non-child resistant conventional packaging may be provided the consumer either at his/her request or at the direction of the prescribing physician. This does not, however, exempt drugs dispensed by physicians from the provisions of the law but rather allows the physician to consciously conclude within the spirit and intent of the non-complying package exemption provision that a particular patient, *ie,* the elderly or handicapped would be unable to gain access to the drug if dispensed in child-resistant packaging. Non-complying packaging is to be the exception rather than the rule, says the Commission. The child protection packaging standards for aspirin and other substances have reduced childhood ingestions by as much as 60 percent while prescription drug ingestions have been reduced by approximately 22 percent. The Commission urges dispensing physicians to play a vital role in increasing consumer acceptance and use of child-resistant packaging by demonstrating its proper use and encouraging the consumer in the importance of its use in reducing childhood ingestions and deaths. ■

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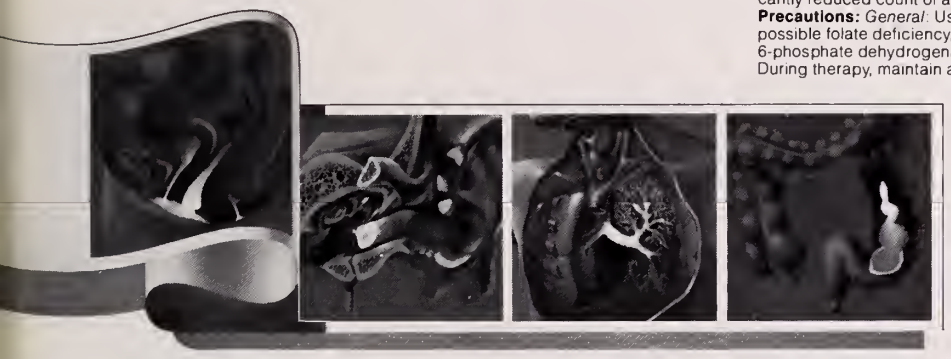

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BACTRIM™ (trimethoprim and sulfamethoxazole/Rocha)
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Indications and Usaga: For tha traatment of urinary tract infactions due to suscaptibla strains of the following organisms: *Escherichia coli, Klebsialla-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* It is racommendad that initial apisodas of uncomplicatad urinary tract infactions ba traatad with a singla affactiva antibacterial agant rathar than tha combination. *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.
For acute otitis media in children dua to suscaptibla strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgmant it offars an advantaga ovar othar antimicrobials. To date, thare are limited data on tha safaty of rapeated usa of Bactrim in childran undar two years of aga. Bactrim is not indicated for prophylactic or prolonged administration in otitis madia at any age.
For acute axacerbations of chronic bronchitis in adults dua to susceptiblo strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* whan in physician's judgmant it offers an advantaga over a singla antimicrobial agent.
For entaritis due to suscaptibla strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicatad.
Also for the treatment of documantad *Pneumocystis carinii* pnaumonitis.
Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.
Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended, therapy should be discontinued if a significantly reduced count of any formed blood element is noted.
Precautions: *General:* Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.
Bactrim may prolong prothrombin time in those receiving warfarin, reassess coagulation time when administering Bactrim to these patients.
Pregnancy: Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.
Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea, pseudomembranous colitis and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.
Dosage: Not recommended for infants less than two months of age.
URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:
Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.
Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.
For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.
ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:
Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days.
PNEUMOCYSTIS CARINII PNEUMONITIS:
Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.
Supplied: *Double Strength (DS) tablets*, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100, Prescription Paks of 20 and 28. *Tablets*, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100, Prescription Paks of 40. *Pediatric Suspension*, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml), cherry flavored—bottles of 100 ml and 16 oz (1 pint). *Suspension*, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).

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1. Rubin RH, Swartz MN: *N Engl J Med* 303:426-432, Aug 21, 1980. 2. Data on file, Medical Department, Hoffmann-La Roche Inc.

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WISCONSIN MEDICAL JOURNAL

NOVEMBER 1982

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President's Page

.....Gerald C Kempthorne, MD

A noble tradition reaffirmed—help for the needy

RECENTLY, THE MEDICAL SOCIETY of Milwaukee County passed a resolution which dealt with the subject of people in need. The opening paragraph stated: "One of the noblest traditions of our profession—one that dates back to the birth of medicine as both a science and as an art—is to render a full measure of service to those in need, regardless of their station in life and ability to pay." The resolution was passed by the Board of Directors and distributed to the membership for support and implementation. The resolution elaborated on the calling of the physician regarding the plight of those in need and unable to obtain medical services. I find this tradition to be an excellent example of the finest tradition of the profession of medicine. It behooves all of us to emulate this lofty calling, as I would like to hope most physicians already do.

A very real possibility exists in our society that a significant number of people are not receiving adequate medical care. It is entirely likely that a "corps of medically needy" exists in our great state. In view of the difficult era we are in, what assurance is there that all people are receiving adequate medical care? Does any responsible party—including government—know whether such a needy group exists? It is assumed that a disparity is present between those individuals who qualify for medical assistance and those who can afford adequate health insurance. It is common knowledge that many respectable people—hit by the recession—are too "proud" to admit their need for help. How unfortunate it would be if virtually *anyone* would have to go without proper medical care in this day and age. Yet, that possibility is real. Surely, no one should be more concerned than the physicians of Wisconsin! Model free clinics do exist in Wisconsin, but they are far and few between.

Dr James Sammons of the American Medical Association has urged state medical societies and groups of physicians across our land to assist in the effort to provide care for those in need. It has been pointed out that in view of the current stringency of federal and state budgets, an early governmental solution is most unlikely. Therefore, it has been suggested that organized medicine and hospital associations encourage their members to meet with business, labor, payers of health care, and other concerned groups to determine the extent of the problem in their communities and to explore ways in which they can jointly develop solutions. The medical profession is the logical body to lead this effort—whether it be at the state level or in the local community.

It is reported that the funding is inadequate for indigent care at the University of Wisconsin Hospital and Clinics. Where do people go today when they cannot afford medical care and are too embarrassed to admit their current "poverty?" How many of our patients actually tell us that they are having financial trouble and need understanding? I would predict that only a few admit their problem, but I also believe many more would if we would encourage the kind of discussion to which the Milwaukee County resolution alludes.

Certainly, no physician is expected to flippantly offer "free" medical care in order to demonstrate a token consideration. However, this is a time when physicians should reflect on the calling of their grand and noble profession. This is the time to extend the helping hand of compassion and concern for those less fortunate. Sincere efforts at rendering some free care to those in need will go much further than charging for care for those unable to pay, thereby necessitating fruitless efforts at collection and undesired alienation. As one mother of five said to me recently as we discussed health care costs: "We can cut out many things in our lives such as going out for dinner, but we cannot cut out going to the doctor, whether we can afford it or not."

No public relations firm can help restore the image of the physician more effectively than for each and everyone of us to be truly aware of the plight of our patients in need. Can you imagine, as a successful professional, how terribly frustrating and embarrassing it would be for you to walk into another professional's office knowing that you couldn't afford his service but needed it? ■

Editorials

WAYNE J BOULANGER, MD, *Editorial Director*

Official positions of the Society will be expressly identified as such; all others are views of the writer and not necessarily those of the Society.

Hip-pointers and bellringers

ON SEPTEMBER 1 a seminar was held at St Vincent Hospital, Green Bay, Wisconsin, not for the medical staff but for the area school football coaches, trainers, and team physicians. The purpose of the seminar was to educate the attendees in preventive medicine regarding strapping, taping, and minimizing injuries to football players and how to deal with the injuries when they occur.

The speakers were Dominic Gentile, chief trainer of the Green Bay Packers football team; Hubert O Tressler, MD, an orthopedic surgeon; and Arthur F Haines, MD, one of the emergency room physicians at St Vincent Hospital.

The surprising part of the seminar was the enormous interest by the local athletic community. The seminar was over-subscribed with many people having to be turned away due to a lack of space. The reason for the vast interest in the seminar was due in part to the fact that trainers are often rotated on teams and coaches are often replaced. They are uncertain as to the proper handling of athletic injuries and they are terribly worried about making mistakes. The speakers of the evening did much to improve the understanding of athletic injuries and showed that the expertise of a skilled trainer can do much to minimize injuries. Some of the injuries described included "hip-pointers" and "turf-toe" and other sports-related injuries which are seldom properly assessed by medical practitioners. Other injuries peculiar to football include the "bellringer" and "spleen popper."

There has been a marked increase of interest in sports medicine among physicians in the last decade, but the direct application of preventive medicine techniques by trainers and coaches is an area that may have been overlooked. These programs can be enormously rewarding and should be encouraged.

—RAM

Silly suits—*ad nauseam*

AN EMPLOYEE ATE a doughnut while at work. (This probably occurred during that national curse and menace known as the inviolable coffee break.) Apparently the doughnut did not rest easily in her stomach and in an inept attempt to induce vomiting she used a pen. Unfortunately, she swallowed the pen and had to be taken to the emergency room. She required two surgical procedures and was unable to work for three weeks.

Then, of course, since the accident occurred at her place of employment, she sued for coverage by workers' compensation. The court found that her injury was not caused by risk incident to her employment and thus was not covered. Incidentally, her place of employment was a medical group where she was a receptionist.—VSF■

Cracker Jack

IN THE LATEST LEGAL news a nine-year-old moppet is suing the manufacturers of Cracker Jacks because her container of the confection did not include the promised prize. It was not stated what degree of pain, suffering, or humiliation she sustained or whether her little psyche was traumatized by the incident.

Imagine what could happen when this litigious little lady matures. Pity the surgeon should she sustain a strabismus of her umbilicus or a scar with a pout instead of a smile by some medical mischance.—VSF

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THE QUESTION OF COMPUTERIZATION

NO. 4 OF A SERIES

Computer languages

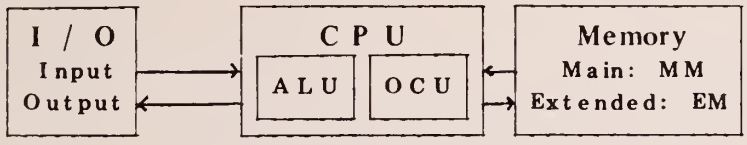
John H Halton, MA, DPhil, FIMA, FBCS, Madison, Wisconsin

THIS SERIES of articles serves two purposes: (i) to acquaint the reader with the principal features of the structure and function of the computer as a tool, and thereby to foster the growth of ***computer literacy;*** *(ii) to assist the reader in making informed and sensible decisions in the selection of a computer system whereby the routine operations of a medical office may be* ***computerized*** *with efficiency, flexibility, and economy. ¶In writing these articles, I am attempting to walk the narrow line between what I perceive as excessive technical detail and what I judge to be vague and insufficient generalities* [I once saw the latter defined as *pornography:* that which titillates the appetite without satisfying it!] *Inevitably, various readers draw their narrow lines otherwise than I do, as is borne out by your communciations. To those who find it hard to see the wood for the trees, I make the suggestion that they should skip judiciously, retaining only the outline of my descriptions. When we have covered what I view as the bare minimum of preliminary explanation and move on to the business of decision and choice, they may wish to continue skimming, or they may find that the details acquire interest and value, as they enter into the process of selection and discrimination. ¶ Others seek more information than I have given here. I am happy to handle their enquiries, either in subsequent articles or privately, as may seem appropriate. In addition, there are many seminars and short courses on various business applications of computers, including medical and dental applications, and the literature on every aspect of computing is large and fast-growing. In response to enquiries for further reading, I have selected the following* pot-pourri, *which is representative but not necessarily optimal for all readers:*

1. Alcock D: *Illustrating BASIC (A Simple Programming Language.)* Cambridge University Press (Cambridge; London; New York), 1978.
2. Arbib MA: *Computers and the Cybernetic Society.* Academic Press (New York; San Francisco; London), 1977. [A new edition is about to appear].
3. Bent RJ, Sethares GC: *BASIC: An Introduction to Computer Programming.* Brooks-Cole Publishing (Monterey, California), 1978.
4. Edwards P, Broadwell B: *Data Processing: Computers in Action.* Wadsworth Publishing (Belmont, California), second edition, 1982.
5. Evans C: *The Micro Millenium.* Viking Press (New York), 1980.
6. Hawkes N: *The Computer Revolution.* E P Dutton (New York), 1972.
7. Kidder T: *The Soul of a New Machine.* Atlantic/Little, Brown (Boston; Toronto), 1981.
8. Kimberley P: *Micro-Processors: An Introduction.* McGraw-Hill (New York; &c), 1981.
9. Laurie EJ: *Computers, Automation, and Society.* R D Irwin (Homewood, Illinois), 1979.
10. Rice JK, Rice JR: *Introduction to Computer Science.* Holt, Rinehart & Winston (New York; &c), 1969.
11. Shelly GB, Cashman TJ: *Introduction to Computers and Data Processing.* Anaheim Publishing (Brea, California), 1980.
12. Welsh J, Elder J: *Introduction to PASCAL.* Prentice Hall (Englewood Cliffs, New Jersey; &c), 1979.
13. Wirth N: *Algorithms + Data Structures = Programs.* Prentice Hall (Englewood Cliffs, New Jersey; &c), 1976.
14. Wu MS: *Introduction to Computer Data Processing.* Harcourt-Brace-Jovanovich (New York; &c), second edition, 1979.

FIGURE 2—*A brief bibliography.*

Of these books, references {2}, {5}, {6}, {7}, and {9} are of general interest and give the reader an understanding of the social impact of the new information processing technology (what I have called the **Second Industrial Revolution***). Reference {8} is a layman's introduction to the hardware engineering side of computer science. The other references are introductory texts on computer applications and programming; the broader computer science texts are {4}, {11}, and {14}, the others concentrating more on computer programming and problem solving. ¶ Having outlined the anatomy of computer* ***hardware****, we are about to embark on the description of computer* ***languages*** *and* ***software****. In this connection, it may be of interest to list the (higher level) languages described in the books referenced in Figure 2:* ***ALGOL*** *in {10};* ***BASIC*** *in {1}, {3}, {4}, {11}, and {14};* ***COBOL*** *in {4}, {11}, and {14};* ***FORTRAN*** *in {4}, {10}, {11},and {14};* ***PASCAL*** *in {4}, {11}, {12}, and {13};* ***PL/I*** *in {4}, {11}, and {14}; and* ***RPG-II*** *in {4}, {11}, and {14}. Among other languages not mentioned in these books but having considerable importance, are* ***ADA APL, C, LISP, SNOBOL*** *(with its dialect,* ***SPITBOL****), and the dialects,* ***WATFOR*** *and* ***WATFIV****, of FORTRAN. ¶ As for the minimum of information which the reader will need to understand what follows, this is summarized below:*



Computer anatomy simplified:

Three parts of a computer:
(1) *Central Processing Unit* (CPU): consists of:
  (a) Arithmetic/Logical Unit (ALU): does the processing,
  (b) Operation Control Unit (OCU): controls instruction execution sequence and interprets each instruction;
(2) *Memory*: possibly of different levels, including (fast, expensive, limited quantity, directly addressable) *Main Memory* (MM) and (slower, cheaper, virtually unlimited, indirectly addressable through I/O ports) *Extended Memory* (EM);
(3) *Input/Output Devices* (I/O): computer's means of communication, including one or more *Terminals* (with input keyboard, and output display or printer).

All *information* (including *numbers*, *patterns*, alphabetical *text*, and *programs*) which is handled by the computer is *digital* in nature (*ie*, may be expressed and processed in the form of finite strings of *characters* selected from a given finite alphabet or font), and is stored in the memory of the machine.

FIGURE 3—*Summary of computer hardware.*

So far, we have described the *hardware* of the computer, lying inert on the dissecting table during our anatomy lesson! What brings it to life is the *software*, the programs which it may be made to execute. To understand this, we must first examine the *languages* through which the computer communicates (the physiology and psychology of the computer, if you will; but I shall pursue the biological analogy no further—nothing is more annoying, in the long run, than the inept attempts of a stranger to "speak our language," particularly when he doesn't understand it very well!)

First of all, the CPU of any computer is designed to accept and execute a specific set of *operation codes* [*op-codes*], ranging in number from a dozen or so to several hundred. Different makes and models of computers and microprocessors may have entirely dissimilar op-codes; but the operations which they represent are much more alike than different, both through functional necessity and historical development. The interpretation of the op-codes is built into the hardware of the OCU [though sometimes the details of interpretation may be modified by the user through what is called *microcoding*] and it is part of this interpretation that the complete instruction being decoded contains a certain amount of further information (such as parameters, indices, and one or more memory addresses). Thus, the "length" of a computer instruction (the number of consecutive memory words, or of bytes, occupied by it) may vary, but the OCU automatically adjusts to this. An *executable program* (sometimes called "object code") consists of a sequence of machine instructions, consecutively stored in the computer's

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memory and (with the exception of "jump" instructions) executed in the order in which they are stored. The aggregate of possible machine instructions is called the *machine language*. In the computer, a program consists of a long string of binary digits (bits), usually written as 0's and 1's; and, of course, the same program would be interpreted quite differently (usually as nonsense) by any computer for which it is not designed. Indeed, the slightest error in a program almost always leads to an error in its output (usually a fatal error!) This state of affairs is sometimes expressed by the computer adage, "Garbage in; garbage out," or just "GIGO." Errors in programs are called *bugs*; and the tedious, odious process of finding and correcting such errors is termed *debugging*. It is estimated that, in the production of a working program, the debugging time may be two to four times as long as the time it takes to plan and write the program initially.

To give the reader a feeling for the nature of machine language, we present a simplified, fictitious, but typical, machine language specification. Our computer has two 16-bit *accumulator* registers [acc], X and Y, which may be coupled into a single 32-bit acc XY, with X holding the more and Y the less significant digits; these are attached to the ALU; and a *program control* register [pc] Z, also of 16 bits, attached to the OCU, which contains the address of the next instruction to be executed. Instructions will contain a 2-bit *acc code a*, with $a=0$ referring to X, $a=1$ to Y, $a=2$ to XY, and $a=3$ to Z. The memory consists of 2^{16} = 65536 16-bit words, directly addressable with a 16-bit address, *n*. There are four *addressing modes*, denoted by a 2-bit *mode code d*, with $d=0$ referring to *absolute address* (address $n|0$ refers to the actual number '*n*'), $d=1$ to *direct address* (address $n|1$ refers to word *n* in the memory), $d=2$ to *indirect address* ($n|2$ refers to the memory address which is the content of the memory word with address *n*), and $d=3$ to *relative address* ($n|3$ refers to the memory address which is the sum of *n* and the content of the pc register Z, with any carry to the seventeenth bit ignored). We will write $\{\{a\}\}$ for the acc denoted by *a*, $\{n|d\}$ for the memory word with address *n* in mode *d*, and C[*x*] for the content of word or acc *x* (so, *eg*, $C[\{n|2\}]=C[C[n]]$, while $C[\{n|3\}]=C[n+C[Z]]$. A *port code p* selects one of 8 *output ports* ($p=0, 1, \ldots, 7$) and 8 *input ports* ($p=8, 9, \ldots, 15$), these ports transmitting 16 bits at once and having to be reactivated before each function (*ie*, each output instruction sends out one 16-bit number, and the machine must wait for the output to be acknowledged before making another output; while each input instruction reads one 16-bit number, if an input is available, and the machine must wait for a new input each time). Finally, a *bit code b* refers to each of the 16 bits in a word (bit 0 being the least significant—rightmost—and bit 15 the most significant—leftmost). In some cases, the codes *a, d, p,* and *b* are interpreted somewhat differently, depending on the particular op-code *c*. The instruction layout is as shown in Figure 4. This 16-bit word is followed, in some cases, by one or two additional words. The op-code *c* has the effect given in Figure 5.

I should explain to the reader that what is important is not the actual set of specifications given in Figures 4 and 5 (though it should be noted that a similar set of specifications, embodying most of the nine operations described there, will apply in any computer), but the kind and complexity of these specifications, and the very limited types of operations provided to programmers who wish to or must write in machine language. They are compelled to walk down their chosen road in extremely short and humanly uncomfortable steps; and though great computer efficiency may thus be attained, and though the longest journey may be made in tiny steps; nevertheless, programmers soon found it unreasonable and intolerable to use machine language.

As an example of a very simple computer program, we consider the solution to the following computing problem. Our computer is to be fed a sequence of one thousand 16-bit numbers at input port #9 [these may be keyed-in by hand or fed-in by a digitizer connected to some experiment]. They are to be stored in memory words with addresses 5000, 5001, 5002, . . ., 5999. Their sum is to be computed and stored in address 6000 and output to a printer through output port #2. The program is to be stored beginning at address 0 in the memory. A possible solution is given in Figure 6.

Again, what is important about this example is not its detailed form, but the difficulty of its interpretation, and therefore also the difficulty of verification and debugging. The programmer must deal with a mass of details which are of a purely mechanical nature and have no relevance to the problem being solved. In the next article, we shall describe the "higher level languages" which are attempts at making the computer understand the programmer's way of thinking, rather than forcing the programmer to think like a machine. The first step is *assembly language*; then there are the languages such as those mentioned in connection with the bibliography in Figure 2. The improvement in intelligibility will (I trust) be striking!

For puzzle-minded readers, I end with some remarks on the program in Figure 6; others may stop here. The first two instructions put zero in address 6000, initializing the summation. The next two in-

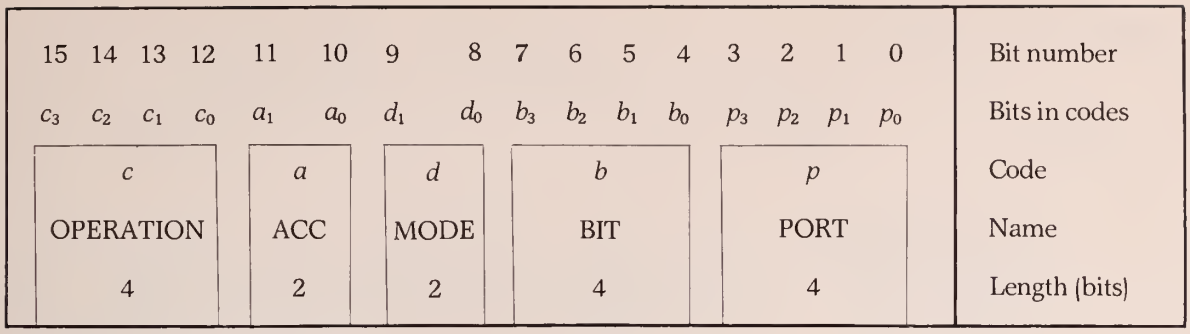

FIGURE 4—*Typical instruction layout.*

OP-CODE	EFFECT	
0	I/0 with $\{\{a\}\}$.	$p_3=1$ for input, $p_3=0$ for output. $a\neq 2$. $b=d=0$. No n.
1	COPY into $\{\{a\}\}$.	Copy $\{n\|d\}$. If $a=2$ & $d=0$, use double length number m, n. $b=p=0$.
2	COPY from $\{\{a\}\}$	Copy into $\{n\|d\}$. If $a=2$ & $d\neq 0$, copy XY into 32 bits $\{n\|d\}$, $\{n\|d\}+1$. If $d=0$; if $a=0$, copy X into Y, if $a=1$, copy Y into X, if $a=2$, copy X into Z, if $a=3$, copy Z into X, and no n. $b=p=0$.
3	CHANGE ACC $\{\{a\}\}$.	CLEAR (i.e., insert zero) if $d=0$; NEGATE (change sign) if $d=1$; COMPLEMENT (**not:** replace 0 by 1 and 1 by 0) if $d=2$; if $d=3$, $a=2$, ROUND-OFF XY into X and clear Y. $b=p=0$. No n.
4	ARITHMETIC & LOGICAL OPERATIONS on $\{\{a\}\}$.	Arithmetic: ADD C[$\{n\|d\}$] to C [$\{\{a\}\}$] and put answer in $\{\{a\}\}$, if $p=0$; SUBTRACT C[$\{n\|d\}$] from C [$\{\{a\}\}$] and put answer in $\{\{a\}\}$, if $p=1$. Logical ops (if corresponding bits of C [$\{\{a\}\}$] and C [$\{n\|d\}$] are α and β, respectively, put γ in corresponding bit position in $\{\{a\}\}$; repeat for all bits): **and** ($\gamma=1$ if $\alpha=\beta=1$, else $\gamma=0$) if $p=2$; **or** ($\gamma=0$ if $\alpha=\beta=0$, else $\gamma=1$) if $p=3$; **xor** ($\gamma=1$ if $\alpha\neq\beta$, else $\gamma=0$) if $p=4$. If $\alpha=2$; if $p<5$, operate on Y with carry into X; if $4<p<10$, operate with XY and 32 bits $\{n\|d\}$, $\{n\|d\}+1$, and if $d=0$, use double length number m, n (i.e., instruction is 3 words long; see op-code 1), and operation corresponds to p-5 (i.e., ADD if $p=5$, . . ., **xor** if $p=9$. $b=0$.
5	SHIFT $\{\{a\}\}$.	Shift to the LEFT if $d=0$ or 2; shift to the RIGHT if $d=1$ or 3; CIRCULAR SHIFT (bits ejected from one end of acc are reinserted at other end, in same order) if $d=0$ or 1; ARITHMETIC SHIFT (ejected bits are lost; on left shift, 0's are inserted from right; on right shift, copies of leftmost bit are inserted from left) if $d=2$ or 3. Shift by p places. $b=0$. No n.
6	JUMP.	Each instruction is executed when C [Z] is equal to its address. On every instruction, the OCU adds to Z the length (1, 2, or 3) of the current instruction, so that Z will contain the address of the next instruction listed in the program [this happens before execution of the current instruction]. In a jump instruction, C[$\{n\|d\}$] is then put into Z, overwriting the address there. (Case $p=0$: equivalent to $c=1$, $a=3$, $b=p=0$). If $p>0$, we have a CONDITIONAL JUMP: C[$\{n\|d\}$] is put into Z if (and only if) condition is satisfied; condition C[$\{\{a\}\}$] = 0 if $p=1$, C[$\{\{a\}\}$] $\geqq 0$ if $p=2$, C[$\{\{a\}\}$] $\neq 0$ if $p=3$, C[$\{\{a\}\}$] >0 if $p=4$, and bit b of $\{\{a\}\}$ = 0 if $p=5$, bit b of $\{\{a\}\}$ = 1 if $p=6$. If $p<5$, $b=0$.
7	BIT operations.	Force bit b of $\{\{a\}\}$ to be: 0 if $d=0$, 1 if $d=1$, or complemented if $d=2$. $d\neq 3$. $b=p=0$. No n.
8	STOP.	Terminates execution.
9	STOP if an INTERRUPT is flagged.	

FIGURE 5—*Typical op-code specification.*

ADDRESS	INSTRUCTION		c a d b p	*address*	EXPLANATION
0	0011000000000000		3 0 0 0 0		X ← 0.
1	0010000100000000	0001011101110000	2 0 1 0 0	6000	C [X] → 6000.
3	0001000000000000	0001001110001000	1 0 0 0 0	5000	X ← 5000.
5	0010000100000000	0000000000011100	2 0 1 0 0	28	C [X] → 28.
7	0100000000000001	0001011101110000	4 0 0 0 1	6000	X ← C [X] -6000.
9	0110000100000001	0000000000011000	6 0 1 0 1	24	Jump to 24 if C [X] = 0.
11	0000000000001001		0 0 0 0 9		Input to X from port #9.
12	0010001000000000	0000000000011100	2 0 2 0 0	28	X → C[28].
14	0100000100000000	0001011101110000	4 0 1 0 0	6000	X ← C[X] + C [6000].
16	0010000100000000	0001011101110000	2 0 1 0 0	6000	C [X] → 6000.
18	0011000100000000	0000000000011100	3 0 1 0 0	28	X ← C [28].
20	0100000000000000	0000000000000001	4 0 0 0 0	1	X ← C [X] + 1.
22	0110000100000000	0000000000000101	6 0 1 0 0	5	Jump to 5.
24	0001000100000000	0001011101110000	1 0 1 0 0	6000	X ← C [6000].
26	0000000000000010		0 0 0 0 2		Output from X to port #2.
27	1000000000000000		8 0 0 0 0		Stop.
28	*Arbitrary: this location is used as work-space for the program.*				

FIGURE 6—*A simple program.*

structions place the initial address, 5000, of our list of numbers to be input, in memory location 28 (it will subsequently contain the next address to be filled)—note the annoyance of having to compute how long the program will be, before being able to allocate this memory register to the task—and then the next two instructions cause a jump of execution to address 24—same problem—if this address is 6000 (which occurs when all thousand numbers have been dealt with). Address 11 contains the one-word input instruction (which is executed for each number in turn), and addresses 12 and 13 contain the instruction which stores the new number in the memory register whose address is contained in location 28 [note the use, and usefulness, of indirect addressing, $d=2$]. The next two instructions add the new number to the partial sum and store the updated sum in 6000. The next two instructions add 1 to the address of the next available store (kept in location 28), and then we jump to the instruction in addresses 5 and 6 to complete the *loop*. The instruction in addresses 24 and 25 is never reached directly (since there is an unconditional jump just before it), but it is reached from the conditional jump in 9 and 10,when the input-and-sum loop is executed 1000 times. Then the program outputs the final sum (stored in 6000) and stops. If the sum were to occupy more than 16 bits, the reader will see that some modification would be needed: this is left as a puzzle for those who have read so far (it can be done, with the codes given here).■

MEB physician directory published. The 1982-83 Directory of Physicians licensed in Wisconsin is now available at a cost of $5.00 per copy plus 5% sales tax. The Directory also contains listings of all state-licensed osteopaths, physical therapists, and podiatrists. Orders may be sent to the Wisconsin Medical Examining Board, PO Box 8935, Madison, WI 53708. *All orders must be prepaid.*

Where have all the platelets gone? —A strategy for monitoring platelet usage

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Milwaukee, Wisconsin

ABSTRACT. *The number of platelet transfusions given to patients in southeastern Wisconsin increased 86% between 1978 and 1981. Forty-one percent of the platelets were transfused during open heart surgery, 35% were given to oncology patients, and the remainder were used to treat patients with miscellaneous disorders. It is important to use this blood component appropriately since the supply of platelets is limited. Audit criteria to help transfusion committees monitor platelet usage are described.*

PLATELET TRANSFUSIONS are used for the treatment of bleeding due to thrombocytopenia or to prevent bleeding in profoundly thrombocytopenic patients. The majority of patients requiring platelet concentrates have leukemia, aplastic anemia and other malignant conditions, congenital or acquired defects of platelet function, or have low platelet counts following massive transfusions of stored red cells.

During the past several years, the usage of platelet concentrates in the 34 hospitals served by The Blood Center of Southeastern Wisconsin increased dramatically. Between April 1, 1977 and March 31, 1978, 17,470 units of platelets were transfused to patients in The Blood Center's service area which includes 1.7 million people in the six-county area surrounding Milwaukee. Usage increased to 32,472 units (an 86% increase) during the 12-month period that ended March 31, 1981. Red cell usage during these two time periods increased only 24% (98,941 units compared to 78,659 units).

Platelets have a short shelf life, and the number available will remain limited because the need for other blood components allows only 50% of the whole blood collected to be processed into platelet concentrates. Hence, it is important for The Blood Center to be aware of trends in usage in order to plan for an adequate supply of platelets.

It is also important to emphasize appropriate transfusion practice. Unneeded transfusions deplete platelet inventories and can potentially deprive needy patients of this component. Hospital transfusion committees and blood bank directors have the responsibility to monitor platelet usage. A set of audit criteria that provides a strategy for determining appropriate use of this component has been developed to help them with this task.[1]

METHODS AND MATERIALS. Log sheets listing patients, diagnosis and the number of units of platelet concentrates prepared for each patient are maintained by The Blood Center. These records were reviewed. Three major diagnostic categories were identified: "cancer and related diseases," "open heart surgery," and "other." The "other" category includes miscellaneous uses of platelets such as those required by patients who were uremic, had massive blood loss, or had disseminated intravascular coagulation. We determined the number of donor platelet units received by each patient in each category. We also calculated the percentage of open heart surgery patients who received platelets at each of the nine hospitals in our area where open heart surgery is performed.

A questionnaire was sent to all cardiothoracic surgeons and anesthesiologists involved in open heart surgery in the Milwaukee area to determine: (1) whose decision it is to order platelets [anesthesiologist or surgeon]; (2) whether platelets are given during or after cardiopulmonary bypass surgery, and (3) the physician's criteria for ordering platelets.

RESULTS. Platelet usage for a three-month period between April 1 and June 30 for the years 1979, 1980 and 1981 were compared. During this three-month period in 1979, 5,319 units of platelets were transfused; 8,811 were transfused in 1980; and 9,763 in 1981. The number of patients receiving platelets at these times also increased from 370 in 1979, to 547 in 1980, and 592 in 1981 (Table 1).

Analysis of platelet usage during the three study periods showed that an average of 41% of all platelets were transfused to open heart surgery patients (range: 38-45%), an average of 35% of the platelets went to oncology patients (range: 28-43%), and an average of 24% to patients in the "other" group (range: 19-27%).

Reprint requests to: Jay E Menitove, MD, Medical Director, The Blood Center of Southeastern Wisconsin, 1701 West Wisconsin Ave, Milwaukee, Wis 53233 (phone: 414/933-5000). Copyright 1982 by the State Medical Society of Wisconsin.

The data were further analyzed to determine the number of platelet concentrates given to each patient receiving platelets in the three diagnostic categories during the three-month study periods. Open heart surgery patients who received platelet concentrates were given an average of 11.7 units. For oncology patients, this figure was 27 units, and for "other" patients it was 15 units. Most of the patients in the latter two categories were transfused on several occasions. Since the clinical conditions varied, further analyses were not made.

Approximately 38% of all patients undergoing open heart surgery received platelets. When analyzed according to hospital, the percentage of open heart surgery patients receiving platelets ranged from 17% to 100%. The number of platelets transfused to each patient varied from 7 units to 16 units per patient.

Responses were received from 45 of the 73 physicians who were sent questionnaires. The replies indicated that ordering platelets for patients undergoing cardiopulmonary bypass surgery was shared by both anesthesiologist and surgeon. Platelets were usually given following discontinuation of cardiopulmonary bypass. Indications for ordering platelets were similar for the surgeons and anesthesiologists and included: use of antiplatelet agents prior to surgery, low platelet counts, prolonged pump time, excessive blood loss, and reoperation.

DISCUSSION. Analysis of the data showed that platelet usage increased in each diagnostic category during the three comparison periods. It appears that the increased number of patients receiving platelets accounted for the increase in usage (Table 1).

Thirty-eight percent of the patients undergoing open heart surgery in our service area received platelet transfusions. Our usage is greater than that reported by others[2,3,4] and probably correlates with the recognition that surgical patients taking aspirin and other antiplatelet agents have increased blood loss.[5,6] Most surgeons have instructed their patients to discontinue these medications one week prior to surgery.

EDITORIAL COMMENT

IT IS LARGELY through the efforts of investigators such as Doctor Aster that thousands of patients benefit from platelet transfusions. However, the authors and other directors of large blood centers now face a growing demand for an expensive, short-lived, and limited product. Doctor Menitove and his colleagues offer hospital blood bank directors a set of guidelines to determine whether platelet transfusions are given to the patients who really need them.

One of the authors' chief concerns is the proportionately large number of patients receiving platelets after open-heart surgery. Even after the surgeons and anesthesiologists were queried, the authors could not account for the wide discrepancy in transfusion practice. In many institutions, platelet concentrates took the place of fresh whole blood and some surgeons use a standing-order involving the use of platelet concentrates irrespective of the patient's condition. Although studies[1,2] have shown that routine administration of platelet concentrates is unjustified, the practice continues. The audit will certainly identify this group.

A separate but equally important issue is the logistics problem. Many times the physician cannot anticipate which patient will develop bleeding problems and require the short-lived, expensive, and scarce product. In order to have the platelets available on the day of surgery, the hospital must order the concentrates in advance from the supplier. If the physician does not transfuse the platelets to his patient, these concentrates may out-date before they can be transferred to another hospital or transfused to another patient. The outdated platelets must be discarded and the cost absorbed by the institution or the patient. For this reason some surgeons transfuse rather than waste platelets. Doctor Menitove did not mention how many units were ordered and not transfused, nor did he elaborate on the policies of the Blood Center concerning the return of unused platelet concentrates.

The audit criteria are reasonable and liberal. Transfusion committees will have charts to review and statistics to gather and discuss long after the patient has been discharged. The authors offer this audit because both medical directors of large transfusion services and principal physicians have been remiss in their responsibility, that of assuring that the indications for platelet transfusion exist *before* the product is given.

The audit may help to identify the inappropriate platelet transfusion, but will this be an effective instrument of change and better utilization? The success of the authors' plan is dependent upon all physicians served by the Blood Center, but in a larger context, good transfusion practice is the responsibility of every physician. Perhaps the editors of the *Journal* will invite the authors to return in a year to tell us whether or not their "strategy" has worked.

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Table 1—*Units of Platelet Concentrates Transfused*

Diagnostic category	*April-June 1979*	*April-June 1980*	*April-June 1981*
Open Heart Surgery	2173 (199)*	3974 (309)	3669 (321)
Oncology	1691 (69)	2462 (96)	4211 (136)
Other	1455 (102)	2375 (142)	1883 (135)
TOTAL	5319 (370)	8811 (547)	9763 (592)

*Number of patients transfused appears in parentheses.

Recently, Harker, et al presented evidence to explain the platelet dysfunction seen during cardiopulmonary bypass. A few of their patients required platelet transfusion even though the platelet counts were greater than 100,000 per cu mm.[7]

The vast majority of our open heart surgery patients underwent coronary artery bypass graft surgery, and as such, form a fairly homogenous group. We noticed, however, a great variation in the percentage of open heart surgery patients receiving platelets and in the dose of platelets transfused to each patient at the various hospitals. For these reasons, questionnaires were sent to surgeons and anesthesiologists involved in performing open heart surgery. Responses to the questionnaires did not provide an answer to the wide discrepancy in ordering practices since the majority of physicians recorded similar indications. We feel this indicates a need for hospital blood bank directors to have objective criteria for monitoring platelet usage.

The Medical Advisory Committee of The Blood Center of Southeastern Wisconsin recently developed audit criteria for use by hospital medical records personnel in conjunction with transfusion or blood utilization committees to monitor platelet usage.[1]

By using the audit criteria, charts of patients receiving platelets would require transfusion committee review unless: (1) the patient is bleeding, and the platelet count is less than 40,000 per cu mm; or (2) the patient is not bleeding, and the platelet count is 20,000 per mm or less; or (3) surgery is planned within 24 hours of transfusion and the platelet count is less than 40,000 per cu mm; or (4) the patient has had cardiovascular surgery and had platelet damage by intraaortic balloon and/or had been on cardiopulmonary bypass for greater than three hours. Charts of all patients with a diagnosis of idiopathic thrombocytopenic purpura who receive platelets would be reviewed.

In order to assure critical thinking about the dose of platelets, charts would undergo review if the patients received greater than 12 units of platelets per day, or less than 4 units per day. Initial platelet dosage should be in the range of one unit of platelet concentrate per 10 kg of body weight. This dosage should provide an increment of approximately 50,000 platelets per cu mm. Platelet counts are required within 24 hours both prior to and following transfusion.

Charts not meeting the criteria are reviewed by the transfusion committee to determine if the transfusions were clinically indicated. An article in the medical staff newsletter stating the number of transfusions meeting the criteria and the reasons for charts not meeting the standards is used to emphasize good transfusion practice.

Since platelet usage has increased markedly and the trend indicates that this will continue, correct use of this blood component is of paramount importance. We urge hospital blood bank directors and transfusion committees to use the audit criteria to assure proper management of a blood component whose expanding usage could outpace supply.

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ABSTRACTS

Acute renal artery occlusion

JAMES R LOHSE, MD; RICHARD M SHORE, MD; FOLKERT O BELZER, MD; Department of Surgery, University of Wisconsin, Madison, Wis: *Arch Surg* 117:801-804 (June) 1982

It is not known if or when the probability of success is sufficient to warrant emergency revascularization of acute renal artery occlusion. This probability depends on the ability of collateral circulation to maintain viability. The role of collateral circulation in maintaining renal viability during 6 and 48 hours of renal artery occlusion has been studied in mongrel dogs. Collateral circulation is sufficient to maintain renal viability beyond the three hours of warm complete ischemia known to cause infarction. It is not sufficient to prevent progressive loss of renal function. Hypertension frequently results. Emergency revascularization of acute bilateral renal artery occlusion, therefore, is indicated. It is not indicated for unilateral occlusion with adequate contralateral function because of the high probability of resulting hypertension. ■

MEDICAL BRIEF

Radiation and cancer

Summary of a report from an American Cancer Society Expert Committee

Prepared by ROBERT H GREENLAW, MD, Marshfield, Wisconsin

THE AMERICAN CANCER SOCIETY recently issued a position paper dealing with Radiation and Cancer.[1] This paper has pertinence to physicians. Since its contents may not be known widely, this report attempts to extract the principal features of the paper and encourages those who are interested to secure a copy of the document,[2] which contains the scientific data used to develop the position taken.

SUMMARY. It is clear that the public sees ionizing radiation more in terms of danger or risk than of benefit.

It is equally clear that while the potential of danger is great, mainly from weapons, the actual harm of radiation has been small in relation to its benefits in medicine and the economy. Radiation has been well-studied and, so far in medicine and industry, well-controlled.

The American Cancer Society can only follow the guidelines it adheres to in all other areas—to look at the scientific and medical evidence, and to take rational positions based on this evidence, always from the point of view of cancer control.

The position paper discusses areas of specific interface:

Diagnostic Radiation: "The rational position would seem to be that they are done (x-ray studies) only when necessary and this can be based only on the physician's judgment. Furthermore, the operators should be well trained; the equipment should be as up-to-date as possible and regularly checked for leakage. According to radiologists who acknowledge the probable risk of cancer caused by x-rays, the benefits of examinations—including the finding of cancer—outweigh the risks by a substantial margin. The Society should support constantly monitoring diagnostic radiology equipment; training personnel; upgrading equipment; improving technique and film to achieve the lowest dose of radiation possible consistent with clear imaging. The Society should leave the decision about ordering x-ray examinations in the hands of trained professionals, i.e., physicians and dentists."

"The Society has stated that chest x-rays as a screening device appear to be of no value in reducing overall lung cancer mortality, and therefore does not recommend the chest x-ray for lung cancer screening examinations in asymptomatic patients."

Regarding mammography, these are the American Cancer Society positions:

"1) Women should have a baseline mammogram between the ages of 35 and 40.
2) Women under 50 should consult their personal physicians about the need for mammography in their individual cases.
3) Women over 50 should have a mammogram every year."

Radiation Therapy:

"Practically all x-ray and gamma ray treatment is used to treat cancer. There is no need to explain the use of radioactivity here, since the disease is recognized as almost 100% fatal if untreated. It has been estimated that radiation treatment cures more than 100,000 cancers each year in the United States."

Nuclear Energy:

"As of now, the only scientific knowledge we have indicates that there have been no cancer deaths related to the release of nuclear radiation either in or outside of U.S. nuclear power plants. Nuclear plants have provided several thousand radioisotopes extremely useful in diagnosing and curing cancer."

"Serious questions have been raised about the general level of man-made radiation to which the population is exposed, and about specific dangers in localities as the result of nuclear contamination, from accidents and weapons tests. The Society's position should be that we are aware of the questions and would like to see them resolved. Until they are, we must counsel utmost prudence. We must rely on what the various commissions and experts recommend about improving safety standards and reducing the risks of accidents."

Regarding a moratorium on construction of new nuclear power plants, the American Cancer Society does not find a scientific consensus on this question and does not take a benefit/risk position.

In the judgment of the Professional Education Committee of the Wisconsin Division of the American Cancer Society, the positions taken are rational. They are recommended to the physicians and dentists of Wisconsin, and to their patients.

Periodically the American Cancer Society assembles an expert committee to review the status of pertinent issues. One such recent committee focused on radiation and cancer. The Professional Education Committee of the Wisconsin Division, American Cancer Society reviewed this report and found its content excellent. The chairman of the Professional Education Committee, Ernest C Borden, MD of Madison, asked Doctor Greenlaw, a radiation therapist at the Marshfield Clinic, to prepare this summary. It was then independently reviewed by Robert W Edland, a radiation therapist at the Gundersen Clinic in La Crosse, who had no criticisms.

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The diagnosis and treatment of depression by the primary care physician

Donald L Feinsilver, MD, Milwaukee, Wisconsin

ABSTRACT: *The primary physician often feels unable to treat depression, but could, by following certain guidelines, render effective treatment. Depression is not simply time limited and has considerable associated morbidity. All FDA-approved antidepressants are effective and the choice of a particular agent is generally determined by past history of response or side effect profile. Adequate serum concentrations and sufficient duration of treatment are necessary. Certain situations, however, require psychiatric consultation.*

"To cure sometimes, to alleviate often, to comfort always." This basic paradigm, so often used by the primary physician, is directly applicable to treatment of the depressed patient. However, often the primary physician finds the depressed patient poses special difficulties and does not feel comfortable or competent in treating depression. This need not be the case.

Errors in the treatment of the depressed patient generally fit into one of two categories. Either the depression is not diagnosed or the depression is diagnosed but not adequately treated. The first type of error may originate from the primary physician's unfamiliarity with the presentation of depression or the atypicality of its presentation. The second type of error can have various origins. The physician may not appreciate the significant morbidity and subjective distress that the depressed patient experiences. The physician may take the approach that a depression is a time limited illness and therefore no treatment is necessary, or he may take the approach that the treatment will not essentially change the outcome of the depression. Furthermore, he may take this latter approach because he feels that he personally is not familiar with the pharmacological and psychological management of depression. The action the physician takes will impact on the course of the depression and will alleviate the patient's suffering. The primary physician can become quite adept in the diagnosis and treatment of depression.

Every primary physician sees a great number of depressed patients.[1] In fact depression is one of the leading reasons for patients coming to the physician's office. At times patients will specifically state that they have been feeling depressed and are, in effect, requesting treatment for this condition; although what the patient means by depression still remains to be determined. Other times patients will come, often repeatedly, to a physician's office with a myriad of somatic complaints. The physician may feel somewhat frustrated at finding no organic etiology for these somatic complaints. However, rather than this being an exercise in frustration and futility, this may help establish a diagnosis in itself, and a diagnosis that is amenable to treatment.

The signs and symptoms of depression can be divided into two different groups. The first group relates to those of dysphoric mood. The patient presents with persistent feelings of sadness, hopelessness, and emptiness. The second group includes a cluster of symptoms that includes, among others, the so-called vegetative signs of depression: sleep disturbance, excessive rumination, appetite disturbance, loss of energy, diurnal variation (feeling worse in the morning), decreased taste, psychomotor retardation, (or at times agitation), anhedonia (inability to experience pleasure), decreased ability to concentrate, self-blame, and self-reproach as well as recurrent thoughts of suicide or death.[2] The issue of the suicidal patient warrants separate discussion. However, in general, for the diagnosis of depression to be made the symptoms and signs should have been present for at least two weeks in order to differentiate depressive illness from a more transient depressive mood.[3]

Next the etiology of the depression must be determined. First, is it secondary to an underlying medical problem such as cardiovascular disease, endocrinological disturbance, neurological disturbance, an infection, a malignancy or very often, a drug reaction? Depression may often be seen in patients receiving certain types of antihypertensive treatment.[4] Secondly, is the depression secondary to another psychiatric diagnosis such as schizophrenia? If the primary physician sees evidence of delusions or hallucinations, he might do well to immediately request psychiatric consultation.

In order to come to this determination, it will be important that the physician take a history of the pres-

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"A mistake commonly made by primary physicians was to assume that if a depression had a psychological basis; that is, if it was 'understandable' why the patient was depressed, pharmacological treatments would be inappropriate. This is no longer the way in which psychiatrists generally divide depressions; and this concept, of not using pharmacological treatment for psychological depressions, is no longer the most commonly held thinking."

ent illness which will include: (1) how the patient is spending his waking hours and what the patient's present sleep pattern is like; (2) medical history; (3) family history (since it is known that depressive illness as well as alcoholism may have some genetic component),[5] and; (4) conduct a careful physical examination.

If the diagnosis of depression is made, treatment can then be initiated. In the past depressions have generally been divided into two groups: those that are so-called endogenous and were felt to have biochemical basis versus those that were so-called neurotic and had a psychological basis.[6] A mistake commonly made by primary physicians was to assume that if a depression had a psychological basis; that is, if it was "understandable" why the patient was depressed, pharmacological treatments would be inappropriate. This is no longer the way in which psychiatrists generally divide depressions; and this concept, of not using pharmacological treatment for psychological depressions, is no longer the most commonly held thinking.

The primary physician will generally have two tools in his armamentarium when treating the depressed patient. First will be psychotherapeutic modalities and the second will be psychopharmocological. The primary physician may feel, and rightly so, that psychotherapies that are insight-oriented are beyond the scope of his treatment. However, he is certainly capable of being a supportive person. Most people tend to respond to depression by adopting a somewhat dependent stance, and the presence of a supportive and concerned physician who engages the patient in a relationship is often invaluable to the patient. This certainly does not negate the use of the second tool —psychopharmacological management, but rather acts synergistically.

Antidepressants have been on the market for a number of years; and it seems that just when the primary physician is achieving some degree of familiarity with antidepressants, out comes a whole new group called "the second generation of antidepressants." Often, now, the primary physician finds himself more baffled than ever. The first consideration is which patient is likely to respond to pharmacological treatment and the second is which pharmacological agent is likely to be most effective. Patients, who present with clear endogenous symptoms and signs, who have a clear onset of the depressive syndrome, a decreased level of functioning, a prior history of drug response, a family history of drug response and/or a family history of affective illness, are those who are said to be in the group of "likely responders."[7] These should be taken as actuarial figures though, rather than absolute guidelines for the prescription of antidepressant medication. Patients manifesting the previously mentioned dysphoric mood and vegetative signs probably warrant a trial of treatment with antidepressant medications.

Generally speaking antidepressant medications may be classified into two groups: (1) the MAO inhibitors, and (2) the tricyclic antidepressants. We might also add the newer tetracyclic antidepressant, maprotiline, to our discussion of this latter group. It is this latter group that is more commonly employed now-a-days and it is this latter group with which the primary physician will want to develop a degree of familiarity.

General thinking is that the tricyclic antidepressants work by increasing available norepinephrine or serotonin by preventing presynaptic re-uptake.[8] Thus the choice of an antidepressant agent basically has two considerations: (1) Which system is it more important to impact on, and (2) what side effects are desired or important to avoid? Regarding the first consideration, some, but not all psychiatrists, believe that there are adrenergic versus serotonergic types of depression. In those patients who are felt to be "low" in norepinephrine, an agent such as nortriptyline, desipramine, or maprotiline should be selected. In those depressions where it is felt that serotinin deficit is primary, an agent such as amitriptyline may be employed.[9] The clinical basis for the distinction would generally be that agitated depressions would be treated with serotonergic agents such as amitriptyline, whereas retarded depressions would be treated with norepinephrinergic agents such as maprotiline.

To further complicate the issue, some psychiatrists do not subscribe to this "two kinds of depression" theory at all and thus feel this distinction is completely arbitrary and should not be the basis of drug selection. A history of a patient responding to a particular medication when depressed in the past, or even a family history of a response to a given medication, may be a strong reason to use that drug again.[10] In general, it would probably be fair to say that all FDA-approved antidepressant medications are about equally efficacious, and an important consideration would therefore be side effect profiles.[8]

Some side effects may be desirable. For example, sedation may be desirable in the agitated patient or in the patient suffering from insomnia, whereas this would hardly be a desired side effect in a patient with a retarded depression. Other side effects are to be avoided. The "older" antidepressants such as imipra-

mine, desipramine, amitriptyline, nortriptyline, protriptyline and doxepine, and "newer-second generation" antidepressant agents such as trimipramine, amoxapine, maprotiline, nomifensin and trazadone, may lie not in terms of efficacy, but in terms of side effect profile.[11] Some of the newer antidepressants may offer certain advantages in this regard.

Generally, one initiates treatment with antidepressants by prescribing a divided dosage such as amitriptyline, doxepin or maprotiline, 25 mg orally three times daily with the intent to gradually increase the total daily dosage and gradually shift most of the dosage to a bedtime bolus. If side effects are not proving problematic, 25 mg may be added to the dosage every two days until a total dosage of 150 mg is reached. After approximately one week of therapy the antidepressant may be given entirely at bedtime. Dosages above this level, often as high as 300 mg per day, are not unknown and are often employed by psychiatrists. However, if this becomes necessary, so probably is the need for consultation; and issues such as serum levels become operative. The serum level that different patients will have at the same dose varies tremendously and clinical efficacy seems to relate to serum level and there may be a phenomenon known as "a therapeutic window" with certain drugs; that is, serum level must neither be too high nor too low.[12]

The patient should be told right from the start what side effects may occur and should also be advised that it will take at least three weeks before his depression is alleviated. Patient noncompliance often arises from the patient not seeing an immediate effect from the medication he is taking. The patient can be told that some of the more benign side effects, such as dry mouth, serve as an indication that the medication is entering his blood stream and will hopefully be ultimately helpful.

In addition to the number of weeks it may take to alleviate the depression, general thinking now is to continue antidepressant medications for approximately six months following a major depressive episode to avoid relapse. This maintenance dosage usually amounts to about one-third of the dosage required to produce remission.[8]

The principal side effects, experienced in varying degrees by different patients, and induced to different extents by various agents are: the anticholinergic effects such as dry mouth, constipation, blurred vision, and nasal stuffiness; the sedative effects; cardiovascular effects ranging from a mild tachycardia to quinidine-like toxicity; orthostatic hypotension which is thought to be related to peripheral alpha-adrenergic blockade; and, the lowering of the seizure threshhold.[8,13]

The primary physician is often most concerned about some of the cardiovascular side effects. Antidepressants can prolong the PR interval and the QRS complex and this may be of significance in certain cardiac patients. Dosage may have to be adjusted in such cases. (Considerations such as the use of electric convulsive therapy requires specialized consultation.) Generally, some suitable regimen for antidepressant usage can be worked out in patients with atherosclerotic heart disease beyond the acute recovery phase of a myocardial infarction, provided they are not in overt congestive failure.[13]

It is important to remember that the anticholinergic effects may be especially problematic in the geriatric population who are particularly sensitive to cholinergic blockade.[14] Dosage must be lowered in this age group so as to avoid inducing a cardiac arrhythmia or a frank anticholinergic delerium. Drug-drug interactions with other anticholinergic medications are also considerations. The first symptoms generally alleviated by antidepressant medications are the sleep disturbance, agitation, reduction in crying spells, whereas the mood elevation itself may not occur for three to four weeks. If after this period of time at an adequate dosage, the patient remains unimproved, psychiatric consultation is clearly indicated. If the primary physician suspects the potential for suicide, psychiatric consultation is immediately indicated. Questions concerning suicide such as "have you ever thought about it" or "how might you go about doing it" should always be inquired of the depressed patient.

"Antidepressants have been on the market for a number of years; and it seems that just when the primary physician is achieving some degree of familiarity with antidepressants, out comes a whole new group called 'the second generation of antidepressants.' Often, now, the primary physician finds himself more baffled than ever. The first consideration is which patient is likely to respond to pharmacological treatment and the second is which pharmacological agent is likely to be most effective."

Referring again to the selection of an agent, it is always a matter of trading off advantages and disadvantages. Amitriptyline will be sedating which will often be useful, but will also be highly anticholinergic. A newer agent, amoxapine, may work slightly faster than some of the other agents and this may prove quite helpful. However, because of its chemical relationship to loxapine, whether or not it may produce extrapyramidal symptomatology and perhaps ultimately tardive dyskinesia, remains to be seen. Maprotiline may have the advantage of being somewhat less inductive of cardiovascular side effects, but it should be used with caution in patients with seizure disorders.[13] Summarizing though, all of these agents are effective in the treatment of depression, and the essential is that a depression not go untreated.

Summarizing, the essential points may be listed. (1) Depression is common. (2) The primary physician should consider a diagnosis of depression when it is possibly present. (3) Depression is an illness, which causes considerable morbidity and occasional mortality, and should not remain untreated. (4) The primary physician should not consider this as simply time limited nor should he consider himself unable to treat this illness, but rather can become quite adept in its treatment. (5) Antidepressant compounds are useful and efficacious in the treatment of depression. The selection of a particular drug may depend on its side effect profile or history of prior patient response, but all FDA-approved antidepressants effectively treat depression in a majority of cases. (6) Antidepressant medications generally have sedative effects and so the addition of antianxiety agents is usually unnecessary. (7) Psychiatric consultation should be sought when the patient appears to be psychotic or suicidal, or is not responding to conventional treatment.

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Abstracts

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Digital video arteriography (DVA), a noninvasive method to evaluate carotid arteries

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Combining computerized digital video image subtraction with a standard fluoroscopic apparatus allows the visualization of intracranial and extracranial carotid arteries with an intravenous injection of contrast medium (Strother et al: *Radiology* 136:781-783, 1980). This technique appears to be a reasonable alternative to standard catheter arteriography.

The value of DVA in the management of 60 consecutive patients was studied. DVA was compared with conventional arteriography in 17 patients and showed excellent correlation.

Fifty-eight percent of patients with suspected cerebrovascular disease had abnormalities of extracranial carotid and/or vertebral arteries demonstrated by DVA. Comparison with Doppler imaging and spectral analysis of carotid blood flow and of carotid radionuclide angiography with DVA was carried out. DVA demonstrated stenosis or occlusion of carotid arteries in 30% of patients with normal Doppler and radionuclide studies.

DVA is an effective means for screening patients with transient ischemic attacks or patients otherwise deemed to be at risk for stroke. DVA produces anatomical data similar to conventional arteriography without the morbidity of the latter. DVA images of extracranial arteries are of high quality and in some instances are a substitute for conventional arteriography. The role of DVA for visualization of intracranial arteries, although promising, is still uncertain. ■

Intraoperative temporal angiography and temporal arteritis

William M Wanamaker, MD; Thomas V Geocaris, MD; Stephen V Somerville, MD, Green Bay, Wisconsin

Diagnosis of temporal arteritis or giant-cell arteritis is a rare cause of headache in the elderly. However, early diagnosis is important since the untreated disease may be associated with abrupt and irreversible loss of vision. Since the treatment with corticosteroids is associated with a high rate of side effects, an absolutely accurate diagnosis is at least desirable if not essential. Even in characteristic cases, a biopsy is generally required. A rare problem in biopsy diagnosis is a false negative biopsy obtained when a normal segment of an otherwise diseased artery is sampled. This presentation described a simple intraoperative selective temporal angiogram which may facilitate the diagnosis with little added risk to the patient. ■

Identification of occult polypharmacy

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DRUG COMPLIANCE PROBLEMS confront the practicing physician on a nearly daily basis. While this most commonly involves suboptimal drug administration, occasionally it reflects a consumption of an excessive amount of drugs. Although the latter is not unique for our time, it has been exacerbated by third-party payers "drug coverage," including Medicaid.

Today, a burgeoning number of patients require regimens of one, two, or more medications to maintain their physico-chemical or psychiatric stability. Often neither the primary physician (if there be one) nor any involved physician is fully aware of the patient's total drug regimen. In many cases only the patient's pharmacist has an inkling of the vast array and quantity of drugs consumed by the patient on a daily or ongoing basis. The patient may be suffering memory and cognitive defects due to drug side-effects, illness, or aging; the family may be unconcerned or unavailable; friends or neighbors may be inadequately apprised of the exact medical situation and the drugs taken, or they may be too timid to interject their opinions. Not uncommonly, a pharmacist may be the most ideal and appropriate person available in identifying and anchoring the patient's drug program in concert with informed physicians.

There is a certain population of patients, however, for which the individual physician and pharmacist has little reliable feedback concerning drug utilization. Included in that population are patients with chronic disabilities, chronic pain problems, psychological disturbances, and drug abuse problems. Such patients often become theatrically-proficient at feigning illness. They commonly are "doctor-shoppers" and have learned from experience that most pharmacists are intelligent, inquisitive, and antagonistic to polypharmacy. Such patients, consequently, may develop a habit of dealing with many physicians and many pharmacies concurrently so that they may surreptitiously obtain, over the short or long-term, multiple drugs in excessive amount, for personal or street use. Identification of these individuals is difficult. Occasionally they may be detected by an alert pharmacist who noticed untoward behavior of the patient during drug dispensation. Subsequent phone communications between the pharmacist and responsive physicians may result in a common awareness of the situation, and ultimately, a resolution of the drug over-utilization problem. In a small number of cases, however, the problem may go undetected for years.

Third-party payers, who provide "coverage" for drugs, may use drug claim data to ferret out such activity. The Wisconsin Medical Assistance Program (Medicaid), by virtue of its federally encouraged Medicaid Management Information System (MMIS) has utilized routine drug claim data to identify individuals over-utilizing or abusing various drugs. In the past year, 140 Medicaid recipients have been identified as so involved. The drugs of concern include narcotics, amphetamine-like drugs, sedatives, tranquilizers, and soporifics. While the majority of the involved recipients have received prescriptions and drugs from four or five physicians and eight to 12 pharmacists, a few have sought drugs from as many as 45 different physicians and 35 different pharmacies in 12 different communities. The most commonly involved drugs in decreasing frequency of use are as follows:

1. Valium (diazepam)
2. Codeine (in combination with aspirin or acetaminophen)
3. Talwin (pentazocaine hydrochloride)
4. Propoxyphene products (Darvon-N, Darvocet N)
5. Codeine-containing cough preparations (usually Ambenyl, Robitussin AC, Hycodan, Tussionex)
6. Percodan (oxycodone)
7. Barbiturates
8. Dilaudid

After the patient has been identified by the claims data, the subsequent effort by the Medicaid Program has been to inform physicians and pharmacists of the findings of the data collection process. This usually consists of a brief explanatory letter to the physician (the originator of the prescription) and, when appropriate, to the pharmacist. The purpose of the letter is: (1) to act as an information source for physicians and pharmacists, (2) to obtain commentary relative to the validity of the data, or in some cases, the rationale for the over-utilization of drugs, and (3) to initiate "due process." Physicians are requested to confront the recipient with the data and to document such confrontation in the medical chart.

From the State of Wisconsin, Department of Health and Social Services, Division of Health, Bureau of Health Care Financing. Reprint requests to: Alfred D Dally, MD, Chief Medical Consultant, Bureau of Health Care Financing, 1 West Wilson St, PO Box 309, Madison, Wis 53701 (phone: 608/266-2522). Copyright 1982 by the State Medical Society of Wisconsin.

We have been gratified by the preponderantly positive response evoked from Wisconsin physicians and pharmacists. In some cases the drug over-utilizers were known to the physicians and were thought to be "controlled;" in many cases the physicians were totally unaware of excessive drug procurement and/or use; and in still other cases the drug over-utilizers were well known to the physicians and/or pharmacists but physicians and/or pharmacists apparently were unwilling, uninterested, or otherwise reluctant to subvert the drug problem.

At times when the abuse appears flagrant (five or more physicians seen, ten or more pharmacies utilized, and narcotics involved), the recipient is strongly encouraged, soon after identification from the claims data, to select one physician to be his or her primary physician and/or is encouraged to select a single pharmacy to deal with; *ie,* the recipient is enrolled in the Wisconsin Medicaid Primary Provider Program. Therein, it is anticipated that: (1) the primary physician and/or pharmacist would educate, curtail and help manage the recipient's drug abuse problem; (2) Medicaid expenditures for drugs would decrease; (3) the quantities of drugs possibly diverted to street traffic would be minimized.

To date, only a small number of recipients have been confined to physician primary providers. There are substantial reasons for that. Currently, Wisconsin Medicaid recipients enjoy unexcelled individual rights which define their freedom of choice of health care providers—including physicians of their choice. Efforts to involuntarily constrain a recipient's care to a primary physician almost invariably has lead to an Administrative Appeal Process—an exceedingly time-consuming and costly affair for the State. Our experience also has indicated that often when the recipient chooses a physician primary provider, that same physician commonly has been culpable of providing unrestrained drugs previously and will continue to do so subsequently. Additionally, recipients involved in drug overuse often encounter great difficulty in securing physicians who will accept the designation and responsibilities of primary provider; *ie*, physicians ostracize them as patients. This dilemma has precluded placement in the physician primary provider program for up to six months. In accord with the above comments, we have found it reasonably appropriate and effective to implement *pharmacy* provider arrangements. Recipients have not generally felt threatened by inroads on their rights when requested to deal exclusively with only one pharmacy—so long as the choice of physician(s) remains unobstructed.

The pharmacy primary provider aspect of drug utilization has proved remarkably beneficial—probably a reflection of two facets: most pharmacists are anxious to eliminate excessive drug use; and even if disinclined to do so, they recognize that their dispensing practice is readily identifiable by the Medicaid Program (particularly under the pharmacy primary provider program), and that such information is freely available to regulatory agencies.

Synopses of two case studies follow:

The recipient is a 61-year-old male. Medicaid claims data indicate that in a nine-month period this recipient had received prescriptions of Dilaudid, Demerol, codeine compounds, muscle relaxants, diazepam, and numerous antibiotics and ear ointments from more than 45 physicians and 12 hospital outpatient facilities in a 125-mile radius of south and central Wisconsin. The prescriptions were filled at more than 28 pharmacies. Office diagnoses were usually "otitis media" or "otitis externa," rarely "degenerative lumbar disc." No physician or pharmacy appeared to have provided services more than three times in that span of time. The recipient ostensibly presented as an eloquent and convincing historian—since not a few of the prescribing physicians are known to be extremely reluctant prescribers of abusive-type drugs.

(No prescriptions were stolen or forged.) Law enforcement and regulatory agencies requested, received, and utilized our claims data relevant to this recipient. That information has been supportive in securing parole revocation.

The recipient is a 33-year-old male who resides in a large southeastern Wisconsin community. Reimbursement claims indicate that in a nine-month period he had obtained an average of 8 to 20 grains of codeine and 60 to 120 mg of diazepam daily from nine pharmacies. Scripts were written predominately by one of four physicians. Office visit diagnoses were "rheumatoid arthritis" and "thoracic spondylosis." While the prescriptions were filled once or twice weekly, specific pharmacies were visited generally no more than once a month, precluding suspicions of drug over-utilization. In this case the "preferred physician" was *most* culpable in overprescribing the codeine and diazepam, and consequently was hardly a physician primary provider candidate. Our initial efforts then were to inform this physician (as well as the other three involved) and the recipient, regarding our data, and then to "lock-in" the recipient to one pharmacist who would act as a "drug manager." The State of Wisconsin Department of Regulation and Licensing requested our data which subsequently was used to support an investigation of this physician's prescribing practices.

Of particular interest and not totally unanticipated, are our findings that only a small number of Wisconsin physicians and pharmacists appear prominently in the claims data collection reports as being involved in a substantial percentage of potentially addictive drugs prescribed and dispensed. These physicians and pharmacists appear to choose to ignore even blatant drug abuse and addiction—for the price of an office call, a drug dispensing fee, or other gratuities. As a matter of fact, of the 140 recipients identified as described above, 13 percent received prescriptions from "Doctor A," 10 percent from "Doctor B," 9 percent from "Doctor C," and 6.5 percent from "Doctor D." The significance of these figures becomes clear when viewed in light of the fact that nearly 6,000 physicians are certified by the Wisconsin Medicaid Program.

Our information has been instrumental in providing supplementary data to federal, state, and local law enforcement and regulatory agencies in identifying and prosecuting those who abuse the rights and privileges of prescribing, dispensing, or utilizing drugs. Further, our computer-assisted data have proved useful in identifying potential sources of inappropri-

ate or inferior quality of Medicaid health-services delivery.

SUMMARY. Wisconsin Medicaid's Management Information System, founded on reimbursement claims, has been instrumental in identifying physicians, pharmacies, and recipients engaged in occult drug over-utilization. Follow-up claims data suggest a notable reduction in drugs procured by identified drug over-utilizers. This results from the fact that such Medicaid recipients have been informed that "someone in Madison" is critically monitoring drugs they obtain via Wisconsin Medicaid, and the fact that most identified physicians, when alerted to possible cases of drug abuse, drastically decrease, better control, or simply refuse to renew prescriptions of drugs with abusive potential. Additionally, some drug abusers have been placed in the Medicaid Primary Provider Program designed to assist them, their physicians, and their pharmacists in dealing with the drug problem. Some of our data have been requested by regulatory and law enforcement agencies, for purposes of supporting pertinent activities of such agencies. Non-Medicaid third-party payers, whose health insurance contracts include "drug coverage," may achieve cost-savings as well as drug abuse control by virtue of a program similar to ours. Cooperative efforts between Medicaid and other health insurance agencies, although desirable and beneficial, are limited because of confidentiality issues. ■

Abstracts

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Myopathy in a patient with amyloidosis and hypothyroidism: morphologic features

Richard J Hodach, MD; Ross Levine, MD; Raymond J Szmanda, MD, Madison, Wisconsin

A 55-year-old white male presented with progressive proximal muscle weakness and pain in these muscles. Examination revealed proximal muscle weakness greater in the lower extremities than in the upper extremities as well as distal muscle weakness in the lower extremities. Laboratory values revealed an erythrocyte sedimentation rate of 18, creative phosphokinase (CPK) 846 Iu/l, and thyroid function studies showed T_3 uptake 40.5% (normal 30 to 40%), T_4 uptake was 4.0 mg% (normal 4.5 to 11.5 mg%), FTI was 4.6 (normal 5 to 11) and serum TSH was 26.5 mIu/ml (normal 2 to 11 mIu/ml). Serum adolase was 17.8 mu/ml. With electrodiagnostic studies, there was evidence of a diffuse, mild, sensory polyneuropathy principally of a demyelinating variety and superimposed ulnar entrapment at the elbow bilaterally. Electromyographic examination revealed excessive spontaneous activity in proximal muscles including doublets, triplets, fibrillations and positive waves. In the upper extremities, there were many myopathic units with rapid recruitment. In the lower extremities, there was evidence of myopathy as well as polyradiculopathy. The muscle biopsy had unusual morphologic features as well as infiltration of amyloid in the blood vessels and muscle.

The morphologic features as seen with histochemistry and electron microscopy were discussed. ■

^{18}F-fluoromethane positron emission tomography to study regional blood flow in cerebral infarction

Gastone G Celesia, MD; James E Holden, PhD; Robert E Polcyn, MD; Robert J Nickles, MD; S John Gatley, PhD, Madison, Wisconsin

Fluoromethane is an inert gas with a blood Ostwald solubility of greater than one at 37 C. This high solubility causes the arterial input function following brief inhalation to closely mimic that of direct arterial administration. Utilizing the cerebral tissue kinetic of ^{18}F-fluoromethane measured by positron emission transaxial tomography (PETT), we have developed a new method to determine regional cerebral blood flow (rCBF). (Holden, et al, *Journal of Nuclear Medicine.* In press, 1981)

Transverse section images of rCBF are acquired using an ECAT II Scanner. Data acquisition is less than ten minutes, thus making possible serial measurements in the same subject at one-hour intervals. The normal pattern of rCBF during rest with eyes opened shows the highest rCBF in the visual and frontal cortices. This correlates well with the high glucose metabolic rate measured by ^{18}FDG PETT.

^{18}F-fluoromethane PETTs were obtained in patients with known cerebral infarction and correlated with computerized tomographic (CT) scans and whenever possible, with ^{18}FDG PETTs. Decreased rCBF was demonstrated in the appropriate territory in every case. Impaired rCBF was noted in cases with normal CT scan.

This is a promising method that will allow serial determination of rCBF. ■

Medullary thyroid cancer in a Wisconsin kindred with Sipple's syndrome: The use of provoked calcitonin testing

Robert S Witte, MD; James R Starling, MD; Thomas Warner, MD; and **Thomas E Davis, MD**
Madison, Wisconsin

ABSTRACT. *A kindred with Sipple's syndrome, or multiple endocrine neoplasia IIa, is described. Medullary carcinoma of the thyroid (MCT) is a constant feature of the syndrome. Provocative testing of serum calcitonin with calcium and pentagastrin administration is diagnostic of MCT. As such MCT is a curable cancer that can be diagnosed and treated at an early stage.*

SINCE SIPPLE[1] FIRST described an association between thyroid cancer and pheochromocytoma in 1961, a body of literature describing syndromes involving abnormalities of endocrine glands has evolved. These groups of disorders are collectively known as multiple endocrine neoplasia (MEN) syndromes. This is a report of a Wisconsin kindred with Sipple's syndrome, or MEN IIa, briefly reviewing the MEN problem, and discussing the use of provocative testing and its role in early diagnosis and treatment of medullary thyroid carcinoma (MCT).

CASE REPORT. The propositus is a 28-year-old man who presented to the hospital with a history of thyroid cancer, diarrhea, weight loss, and paraparesis. Five months earlier he had developed refractory diarrhea. Two months before admission he underwent a neck exploration for a thyroid nodule which was diagnosed as poorly differentiated follicular carcinoma of the thyroid metastatic to left cervical nodes. His diarrhea continued and he developed bilateral cervical lymphadenopathy which did not take up I^{131}. Several days before admission to this hospital he noted bilateral leg weakness.

On physical examination he was a cachectic, normotensive male with massive bilateral cervical lymphadenopathy and a nonspastic paraparesis. A chest roentgenogram showed a diffuse, reticulonodular infiltrate and a large anterior and superior mediastinal mass. Metrizamide myelography demonstrated a complete block at L3 from an epidural mass. Hematologic parameters were normal except for hemoglobin concentration of 10 Gm/dl. The serum alkaline phosphatase was 165 U/L (normal 20-110 U/L), the serum lactate dehydrogenase was 495 U/L (normal 90-200 U/L), and the serum glutamic-oxaloacetic transaminase was 153 U/L (normal less than 36 U/L). Histologic sections of the thyroid tissue were reviewed and showed a solid anaplastic tumor with residual follicular structures and a focal trabecular pattern. There were large tracts of fibrosis, and hyaline material containing calcific deposits. The amyloid was negative. However, amyloid fibrils and cells containing electron dense granules were found on electron microscopy of paraffin embedded tissue. Argyrophilic granules were demonstrated in some cells. A random serum calcitonin was greater than 10,000 pg/ml (Bioscience Laboratories, normal less than 50 pg/ml).

He was treated with corticosteroids and radiotherapy to the lumbosacral spine. On the fifth hospital day he became dyspneic, hypoxic, and lethargic. A chest roentgenogram showed progressive interstitial infiltrates. Despite intensive therapy he

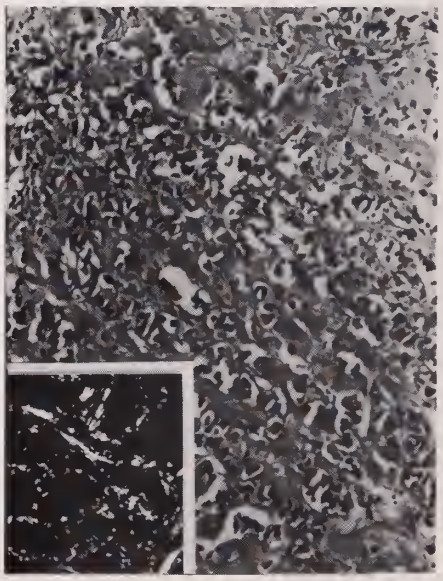

FIGURE 1—*Tumor cells embedded in a hyaline stroma (H&E x125). Insert: birefringence of amyloid stained with Congo Red (x300).*

From the Departments of Human Oncology, Surgery, and Pathology, University of Wisconsin Clinical Science Center, Madison. Publication support provided. Reprint requests to: Robert S Witte, MD, Dept of Internal Medicine, Section of Medical Oncology, Gundersen Clinic, Ltd, 1836 South Ave, La Crosse, Wis 54601 (phone 608/782-7300). Copyright 1982 by the State Medical Society of Wisconsin.

deteriorated rapidly and died in respiratory failure. Widespread metastatic medullary carcinoma was found at post-mortem examination (Fig 1). A pheochromocytoma (8 Gm) was present in the right adrenal.

Because MCT is in many cases a component of a heritable syndrome, this kindred was extensively evaluated. The propositus was one of five siblings. The mother died of gastrointestinal hemorrhage and at post-mortem examination was found to have bilateral pheochromocytomas. All four siblings were asymptomatic and had normal physical examinations. Provocative testing using a calcium and pentagastrin stimulus as described by Wells *et al*[2] with measurements of serum calcitonin done at 0, 2, 3.5, 5, and 7 minutes was performed on these siblings.

The provocative test in one of them was markedly abnormal (Fig 2). In addition, this 26-year-old male had hypophosphatemic hypercalcemia of 11.3 mg/dl with a serum parathyroid hormone level of 1260 pg/ml (Bioscience normal <1800 pg/ml) all compatible with primary hyperparathyroidism. Urinary excretion of vanillyl mandelic acid, metanephrines, and free catecholamines were normal. He had normal serum T_4, T_3-resin uptake, free thyroid hormone index, and thyroid scan. Intravenous angiography demonstrated a lesion in the right inferior neck compatible with an enlarged parathyroid gland. The patient had a thorough neck exploration with total thyroidectomy and right inferior parathyroidectomy. Histopathology of the operative specimens was that of bilateral, multifocal MCT (Fig 3) and C-cell hyperplasia as well as parathyroid hyperplasia. The tumor cells contained typical electron-dense granules (Fig 4) and calcitonin was demonstrated in hyperplastic C-cell nodules by immunocytochemistry. Postoperative serum calcium levels have been normal and provocative testing three months postoperatively for serum calcitonin has shown slightly elevated stimulated levels (Fig 2).

Among the five siblings there are eight offspring, aged three months to nine years, who have as yet not been evaluated.

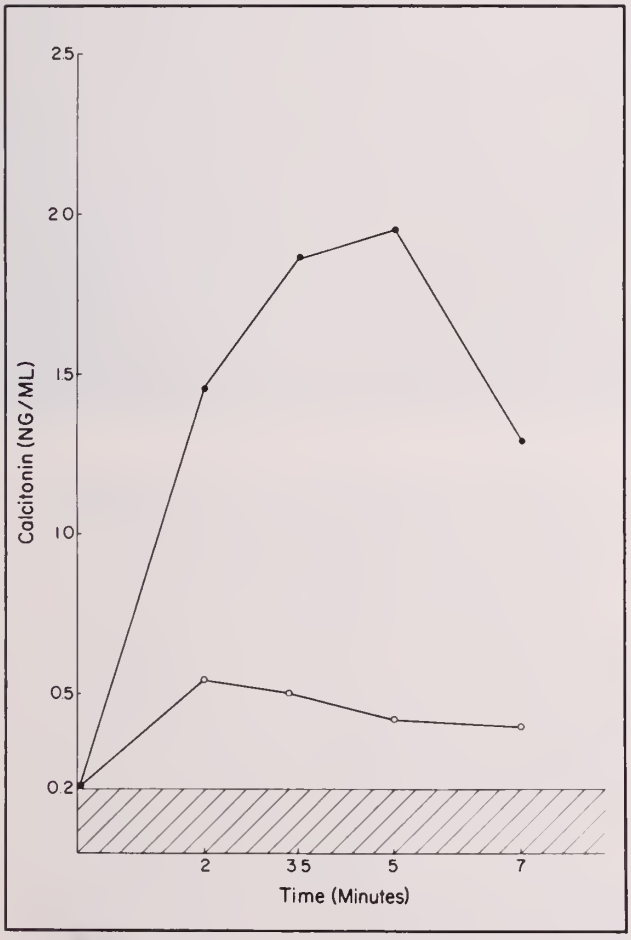

FIGURE 2—*Results of the preoperative (•———•) and postoperative (°———°) calcitonin levels drawn 2, 3.5, 5, and 7 minutes following the intravenous administration of calcium gluconate (2 mg Ca^{2+} /kg/1 min) followed immediately by pentagastrin (0.5 μg/kg/5 sec).*[2]

DISCUSSION. There are presently three well recognized MEN syndromes. Wermer's syndrome or MEN I involves tumors of pituitary, pancreatic islet cells, and parathyroid glands. MCT, pheochromocytoma, multiple neurofibromata, intestinal neuroganglioma-tosis, and a marfanoid habitus comprise MEN IIb. Sipple's syndrome (MEN IIa), of which this family is a prime example, is characterized by MCT, pheochromocytoma, and parathyroid abnormalities.[3] Mixed multiple neoplastic endocrine syndromes have been described recently.[4,5]

MEN IIa is inherited as an autosomal dominant with high penetrance and variable expression.[6] The marker abnormality in Sipple's syndrome appears to be MCT. In a 1973 NIH series all affected members of a typical kindred had MCT.[7] Clinical or anatomic evidence of parathyroid disease and pheochromocytoma was present in 64% and 44% of those with MCT, respectively.[7] These data are in contrast to an incidence of 10% with parathyroid disorders and 33% with pheochromocytoma as reported in the Johns Hopkins experience.[3] While the statistics may vary from one series to another, the fact remains that without MCT the rest of the triad is unlikely to be present.

MCT is a neoplasm of the parafollicular cells (C-cells) of the thyroid gland.[3] These cells secrete calcitonin which can be readily measured by radioimmunologic techniques. Abnormally high unstimulated levels of calcitonin are virtually diagnostic of MCT. However, a normal random calcitonin level may be seen in any condition from C-cell hyperplasia (the premalignant precursor of MCT), to overt MCT. Stimulation of the C-cells by calcium and pentagastrin infusion as described by Wells *et al*[2] can be diagnostic of these parafollicular cell abnormalities, whether they are the precancerous hyperplastic lesions or frank cancer (see Figure 2 legend for test protocol).

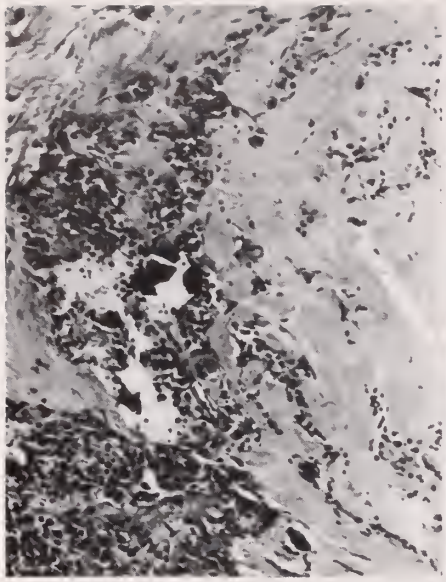

FIGURE 3—*Thyroidectomy specimen containing nests of Tumor cells embedded in a hyaline stroma with focal calcification (H&E x125).*

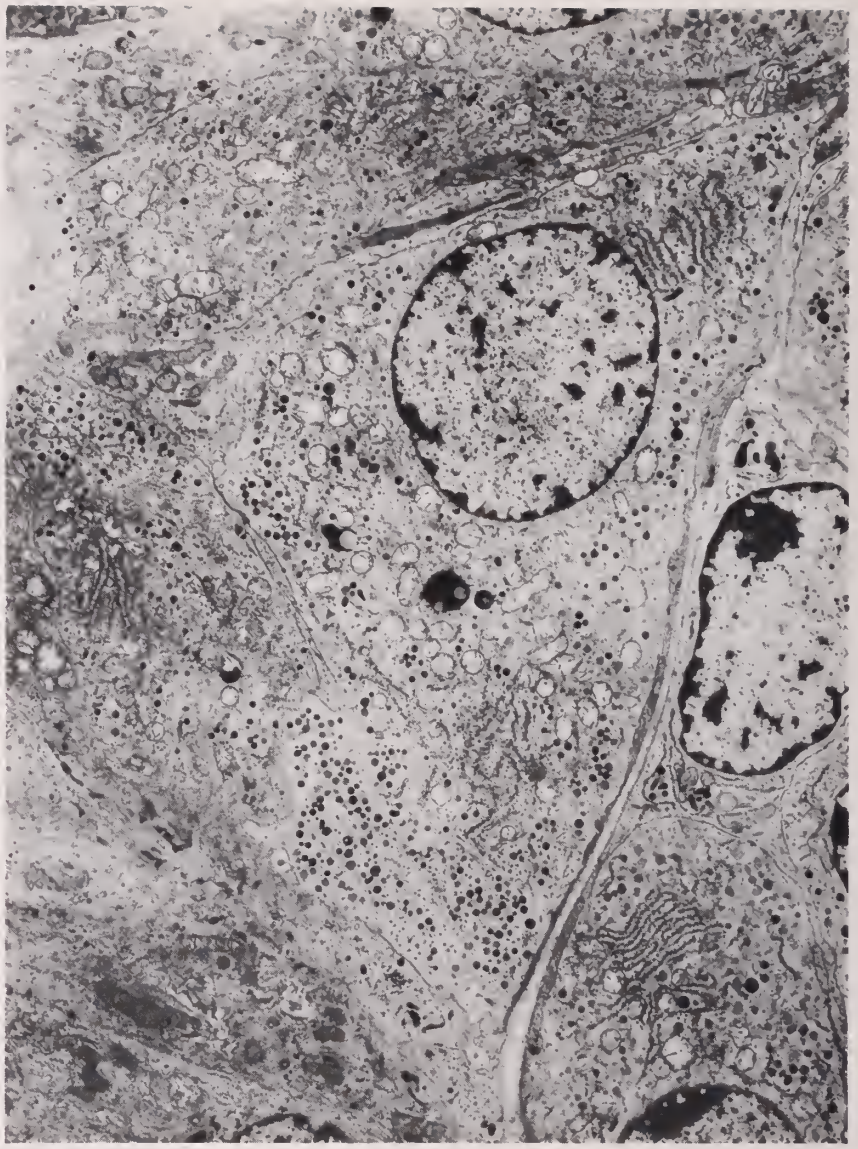

FIGURE 4—*Note multiple round electron dense granules of even size in tumor cells (x12,000).*

The utility of this provocative screening test has been demonstrated by Graze *et al.*[8] Their studies indicated that by frequent screening of a kindred at risk, progressively smaller, less disseminated, and more unilateral cancers were discovered.[8] Wells[9] has proved that those patients who have the diagnosis of MCT made biochemically, rather than clinically, are in a more favorable stage, younger in age, and more likely to be cured with surgery.

Provocative testing can be used also to assess the surgical result. A 90% five-year disease-free survival is seen in those patients with an immediate postoperative normalization of stimulated calcitonin levels.[9] At times, the stimulated calcitonin may improve but not normalize, which was the case in the sibling of the propositus described above. This is not an unusual circumstance and does not always portend a poor prognosis. Block *et al*[5] found persistently elevated levels of stimulated calcitonin in 18 of their 56 patients. Exhaustive tests failed to elucidate the source in most of these patients, and they remain well with stable calcitonin levels over an average of 7.3 years of follow-up. This is similar to the experience reported by Stepanas *et al*[10] as well as Ulbright *et al.*[11] Residual, quiescent MCT or some hyperplastic C-cell remnants are probably the source of the calcitonin. These patients should be screened periodically with provoked calcitonin tests since marked elevation may be a harbinger of clinical recurrence.

While representing only 6% to 10% of all thyroid cancers MCT is unique in that it can occur as a familial syndrome and elaborates a substance that can be quantitated even in microscopic, subclinical disease. When found under such circumstances, there is an excellent chance for cure by total thyroidectomy. All members of a kindred in which MCT is discovered should be evaluated for parathyroid abnormalities and pheochromocytoma, as well as undergo provocative tests of calcitonin secretion. Once screened, these family members should be rescreened for MCT on at least a biannual basis. The children of all affected kindreds should be screened when they reach the age of ten years, as we are planning to do with this family. This allows early diagnosis and treatment of a potentially curable cancer.

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NIH CONSENSUS DEVELOPMENT CONFERENCE

Computed tomographic scanning of the brain

A Consensus Development Conference held at the National Institutes of Health November 4-6, 1981 reviewed scientific evidence related to computed tomographic scanning (CT) of the brain.

At NIH, Consensus Conferences bring together research investigators, practicing physicians, representatives of consumer and special interest groups and others to make a scientific assessment of medical technologies and to seek agreement on their safety and effectiveness. After hearing data presented by experts in CT scanning and considering audience discussion, a Consensus Panel of specialists and generalists issued a statement addressing key issues relating to CT scanning of the brain. Following is a summary of that statement:

CT scanning of the brain is a safe, accurate, and powerful tool in the primary diagnosis of brain tumors, brain hemorrhage, major head injury, and certain brain infections. CT scanners have been a major factor in decreasing deaths, especially in severe head injury and brain abscess, and the presence of these conditions clearly calls for the diagnostic assistance of the CT.

While there are numerous indications for use of CT, it should not be employed as a "routine screening procedure" when patients show little likelihood of having structural disease such as in cases with minor head trauma or simple headache.

Among the indications for use of CT are when there is suspicion of arteriovenous malformations, hydrocephalus, herpes simplex encephalitis, parasitic infestations, progressive degenerative diseases of the brain, and intracranial tumors. In primary brain tumors, CT has resulted in the detection of smaller lesions, lower death rates following surgery, and decreased time in the hospital.

CT usually will differentiate between ischemic and hemorrhagic intracranial lesions—helping the physician to select appropriate medical or surgical therapy. And CT is helpful in identifying potential structural causes of complex partial or focal epileptic seizures. CT also is an important clinical tool in pediatric neurology that should be used to evaluate undiagnosed coma and other neurological symptoms.

Although CT does carry potential hazards, including a small risk of adverse reactions to contrast material—if used—the procedure is "remarkably safe." The amount of radiation produced by the CT is comparable to or less than that emitted from many other routine diagnostic procedures, including dental X-rays. Physicians should, however, use special care in ordering multiple scans for children since "the effects of repeated cumulative low-level radiation doses to the immature, developing brain are yet unknown.

Despite its wide use, CT "may not be sufficiently available for the public to derive the full benefit of its potential." Evidence indicates an insufficient number of the instruments in some large metropolitan areas, in medically underserved areas, and in sparsely populated regions which experience a high incidence of head trauma.

Copies of the full Consensus Statement on CT Scanning of the Brain and bibliography may be obtained from the Office for Medical Applications of Research, Building 216, National Institutes of Health, Bethesda, Maryland 20205. ■

Perinatology

Editor: LUIS B CURET, MD
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The current role of fetoscopy . . .

David B Schwartz, MD, Madison, Wisconsin

EDITORIAL NOTE: *Fetal surgery for diagnostic and therapeutic purposes is being performed in a number of medical centers. Perinatalogists must be aware of the potential of such procedures in order to provide selected patients therapeutic alternatives previously not available. The accompanying article reviews the role and clinical applications of fetoscopy in general and summarizes the current experience at the University of Wisconsin—LBC*

THE WORD FETOSCOPY is derived from the Latin word "fetus" and the Greek word "scopien"—to view. It is a procedure which involves the introduction of a very small diameter endoscope percutaneously into the amniotic cavity thereby allowing direct access to the fetus. It is primarily a diagnostic procedure and information about the fetus is obtained in two ways: visualizing external anatomy and/or by obtaining fetal tissue for diagnostic tests. The tissues used have included skin, liver, or fetal blood obtained from the surface vessels of the placenta. The earlier attempts at this procedure were motivated by an inability at that time to evaluate the fetus directly. These initial fetoscopic procedures were generally unstructured assessments on small numbers of patients, and were performed as part of a termination of pregnancy either by hysterotomy or dilatation and curettage. Many of the patients were examined under general anesthesia, and it was clear that the potential morbidity and practical disadvantages of fetoscopy performed in this manner would significantly limit its practical use in the clinical setting. However, over the last ten years instruments have been refined, and with the appropriate use of suitable animal models to evaluate safety and develop expertise, the techniques have been carefully applied in a structured fashion to the prenatal evaluation of human pregnancy.

Clinical applications of fetoscopy. Fetoscopic visualization allows for the direct evaluation of fetal external anatomy, and makes possible the diagnosis of certain external structural malformations that cannot currently be achieved with ultrasound. To justify the potential risks of the procedure, these components must be of well-defined syndromes which have other associated serious defects necessitating either institutionalization or causing neonatal, infant, or childhood death. Such structural malformations include polydactyly, syndactyly, cleft lip, cleft palate, and certain abnormalities of the external ear. This use of fetoscopic visualization has been made clinically for the prenatal diagnosis of such conditions including the Ellis-van Creveld, Lawrence-Moon-Biedl and Smith-Lemli-Opitz syndromes,[1,2,3] as well as Hirschprung's disease with associated congenital cardiac anomalies.[4] Its role in the prenatal evaluation of skeletal dysplasias would therefore be directed at confirming ultrasound-derived data of skeletal abnormalities if this was equivocal and/or looking for corroborative data. While alpha fetoprotein measurements and ultrasound are the best current methods for neural tube defect screening and diagnosis, fetoscopy may also play an ancillary role in resolving inconclusive information obtained by these techniques.

Fetoscopic skin biopsies have been successfully obtained in the evaluation of genetically determined dermatoses including congenital bullous ichthyiosiform erythroderma and epidermolysis bullosa.[5] Furthermore, a fetoscopically directed fetal liver biopsy has permitted the diagnosis of ornithine carbamyl transferase deficiency.[6]

Although fetal blood sampling has been used to evaluate a number of genetically determined disorders, the main application of this technique has been for the diagnosis of hemoglobinopathies, where it has largely replaced percutaneous placental aspiration of fetal blood. The recent advances in molecular biology and recombinant DNA techniques should decrease the need for this procedure as more information becomes available from the DNA of fibroblast cultures obtained by amniocentesis. There will still be the need for blood sampling in those cases where this information is equivocal or cannot provide an explicit answer.

Procedure. Preliminary ultrasound scanning of the uterine contents is undertaken to establish placental position, exclude a multiple pregnancy, determine the lie and orientation of the fetus, measure the biparietal diameter, and determine a safe site for the introduction of the instrument. It is customary to sedate the patient 1/2 hour before the procedure (Diazepam 10 mg) and following surgical preparation of the abdomen the procedure is per-

From the Department of Obstetrics-Gynecology, University of Wisconsin, and the Wisconsin Perinatal Center, Madison General Hospital, Madison, Wisconsin. Publication support provided. Reprint requests to: David B Schwartz, MD, Wisconsin Perinatal Center, 202 South Park St, Madison, Wis 53715 (phone: 608/267-6000). Copyright 1982 by the State Medical Society of Wisconsin.

formed under sterile conditions. The selected site is infiltrated with local anesthetic and the trocar and cannula introduced into the amniotic sac under continuous ultrasound monitoring using a sector scanner, with the hand held transducer enclosed in a sterile polyethylene bag.[7] The visualization process is a combined synchronous procedure, with the ultrasonographer guiding the fetoscopist to the desired areas that need careful visual assessment. This synchronous use of ultrasound will improve the safety of the procedure, minimize fetal trauma, inadvertent placental damage, and improve the chances of successful visualization.[8]

Fetal blood and tissue sampling is performed under direct vision using either the Hobbins cannula which incorporates an additional channel for this purpose, or a fetoscope with an equivalent channel in the instrument itself. Skin biopsy should, if possible, be obtained from the scalp for future cosmetic reasons, and blood sampling from surface placental vessels close to the cord insertion. Using this site and a No. 27 gauge needle, blood loss from the puncture site is minimal and stops in a matter of seconds.

With combined synchronous ultrasound, successful, regional inspection can be achieved in a significant number of cases even after 16 weeks.[8] If blood is sampled, the procedure is best performed after 18 weeks.

An anterior placenta does not preclude fetoscopy, as careful ultrasound scanning can usually demonstrate a placental-free area for the safe introduction of the instrument.

Development of fetoscopy at the University of Wisconsin. Prior to using fetoscopy for clinical purposes, it is essential to develop expertise with the equipment. In the centers in which this facility has been established, this experience has been obtained by performing the procedure on volunteer patients who are undergoing elective second trimester termination of pregnancy. In Madison these patients were approached to participate in the development of this project after the protocol had been approved by the Committee for the Protection of Human Subjects. The project was developed in two phases. The first was that of fetoscopic visualization and the second was to be directed at tissue sampling.

In the first phase, in addition to developing skills, aspects which were critically evaluated were the extent to which anatomical visualization was possible and the influences of gestational age and placental position on this procedure. Furthermore, the equipment and techniques required to document visual findings were also studied. This phase was completed on the first 36 patients studied and the results indicated that if the amniotic fluid was clear, the extent of visualization was not significantly influenced by advancing gestational age between 18 and 23 weeks.[8] Furthermore, the areas that could be visualized were usually sufficient to be able to realistically use the procedure diagnostically in appropriately selected cases. The anterior placenta was not found to be a significant problem in gaining access to the fetus, corroborating the work of others. Finally, using selected standard photographic and lighting equipment, accurate documentation and recording of visual findings was possible.[9]

Table 1—*Fetoscopic blood sampling*

VOLUME: 10 μl-700 μl

PURITY: 75-100%

WHITE CELLS: 5-9000/ml

Segs	*Bands*	*Nucleated RBC*	*Lymphocytes*
16	0	+ +	62

FETAL KARYOTYPING: 5/6 Attempts

Table 2—*Complications of fetoscopy*

MATERNAL	FETAL
Trauma—Abdominal wall	Abortion
—Bladder	Trauma
—Uterus	Premature labor
Hemorrhage	Premature rupture of membranes
Infection	

The second phase is currently being developed and the initial emphasis is on fetal blood sampling. Selected data from the first 14 blood samples have been summarized in Table 1. These results confirm that it is possible to draw pure samples and successfully obtain fetal karyotyping in spite of the small volumes used.

Complications. The complications of this procedure may be either fetal or maternal and have been listed in Table 2. Currently the immediate loss rate from abortion is probably slightly less than 5%. Later problems will include premature labor (7-10%) and possible drainage of amniotic fluid. This latter problem has not appeared to inevitably lead to premature labor and fetal loss.

Conclusions. Fetoscopy, being an invasive procedure, and associated with a relatively significant fetal loss, is only indicated for prenatal diagnosis when alternative less invasive or noninvasive procedures such as amniocentesis and/or ultrasound are unable to provide the required information. Furthermore, in view of the complication rate associated with this procedure, it will only be indicated for those conditions in which the chances of the fetus being affected exceed the risks that have been outlined.

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JOINT COMMISSION ON ACCREDITATION OF HOSPITALS. . .No. 1 of a series

Accreditation issues . . . John E Affeldt, MD, *President* JCAH

QUESTION: *Why is JCAH field testing its rewritten standards, and how does this process work?*

ANSWER: *At its April 1981 meeting, the Board of Commissioners of the Joint Commission on Accreditation of Hospitals (JCAH) voted to rewrite hospital accreditation standards to make them less prescriptive, more flexible, and reflect current practice. Those sections of standards relating most directly to the quality of health care were selected to be rewritten first.*

IN LATE 1981, THE JCAH mailed the proposed, rewritten standards to 2,500 hospitals and national health care organizations for review and comment. The results of the first field review were positive, with a 91% satisfaction rate with the content and a 95% satisfaction rate with the format. However, the field review also revealed concerns about the surveyability of the standards.

To evaluate the surveyability of the rewritten standards, JCAH designed a "field test" to answer the following questions:

1) Will the proposed chapters/standards clearly communicate a consistent meaning to hospitals?
2) Will a hospital and a JCAH surveyor agree on the meaning of the proposed chapters/standards, and on the extent of the hospitals compliance with them.
3) Will different surveyors reach the same conclusions in the same hospital?

The field test was conducted in May and June of this year. Hospitals in similar geographic locations that were already scheduled for survey were invited to participate on a voluntary basis in the field test. Accreditation decisions were based solely upon the existing *AMH* standards and current survey procedures for the 82 hospitals that volunteered to participate in this study. All other information derived from the field test was used to assess the proposed standards for clarity of meaning, achievability, nonprescriptiveness, and surveyability.

The field test addressed the issue of surveyability in two ways. First, each participating hospital was surveyed by a physician or administrator surveyor using standards contained in the current *AMH*, as well as one or two of the rewritten chapters.

Second, another surveyor returned within a week or two, at the Joint Commission's expense, to conduct a follow-up visit, evaluating the same current and proposed standards used during the initial survey. At the completion of the follow-up visit, the surveyor interviewed key hospital staff to address such issues as the hospitals' interpretation of the rewritten standards, as well as problems the hospital staff encountered in complying with the proposed standards.

Based on the results of the field test, JCAH will consider any needed revisions in the proposed standards prior to a second field review. After completion of the second field review, the standards will be revised again prior to final consideration by the Board of Commissioners in December 1982. If the Board approves the rewritten standards, they will be published in the January/February issue of *JCAH Perspectives* and become effective for survey purposes in July 1983. ■

This series is prepared by the Joint Commission on Accreditation of Hospitals as an informational aid to physicians. Questions, comments, or suggestions for future articles should be directed to: Diane M Gabriel, Program Manager, Marketing Communications, Dept of Public and Professional Relations, JCAH, 875 N Michigan Ave, Chicago, Ill 60611; phone: 312/642-6061, ext 214.

Organizational

Resolution deadline for Annual Meeting: January 24

The 1983 House of Delegates Sessions will be held March 24-26. All resolutions must be submitted in proper form to the Secretary's office at SMS no later than January 24, 1983 (two months prior to the first session of the House). It is important that county medical societies, specialty sections, and members submit resolutions early to facilitate early distribution of materials and allow delegates to adequately represent their county medical society or specialty section. If a resolution involves expenditures, a "fiscal note" must accompany the resolution. SMS staff is available to assist in preparation of fiscal notes. The first session of the House will convene on March 24 and the second and third sessions will be on March 25, 1983. ■

New Avis discount rate

SMS Services, Inc has been informed by Avis that a significant improvement in the car rental discount program for SMS members was effective November 1. Beginning on that date, members who display their sticker when renting a car from Avis will receive a 13% discount (previously 10%) off unlimited time and mileage rates. The 40% discount off normal time and mileage rates is still available, but in nearly every instance this would result in higher charges than the unlimited time and mileage rates. ■

Brozek leaves SMS staff

SMS Public Affairs Coordinator Michael Brozek resigned from his position on the SMS staff effective October 18 to become chief executive of a Washington-based trade association. Brozek had been with the medical society since 1975 when he joined the SMS Physicians Alliance as a field consultant. ■

Blue Book–Update

In the listing on page 111 of the July 1982 BLUE BOOK, under the Committee on Alcoholism and Other Drug Abuse, the following addition should be made:

Herbert White, DO, Genesse Depot, 1985. ■

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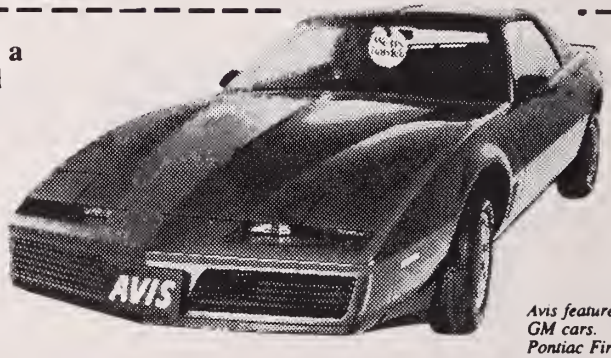

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MEMBERSHIP UPDATE

The following physicians, by county medical society, have recently been elected to membership, or have been reelected or reinstated since publication of the Membership Directory in the January issue of the *Wisconsin Medical Journal,* with the specialty abbreviated above the name:

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FP
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Green Bay WI 54302

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IM
Hoegemeier, Harry W
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Green Bay WI 54303

IM
Koehler, Thomas F
1751 Deckner Ave
Green Bay WI 54302

DANE

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Madison WI 53705

Brandl, Joyce A
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Madison WI 53713

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4405 Mandrake Rd
Madison WI 53704

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Sun Prairie WI 53590

P
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Madison WI 53792

N
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504 Sheldon
Madison WI 53711

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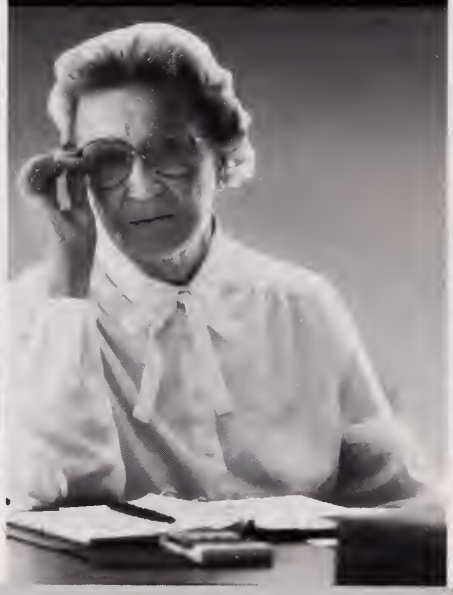

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An example for healthcare cost containment

Nelson Industries, with headquarters in Stoughton, Wisconsin, decided to "do something" about a 77% increase in its healthcare costs in the last two years while the net pay of its workers decreased 25%. Its president, Rockne Flowers, who is also president of the Wisconsin Association of Manufacturers and Commerce, recently outlined a new health program which will affect services and benefits provided to 1,100 employees in nine locations: Stoughton, Muscoda, Mineral Point, Black River Falls, Arcadia, Bloomer, Viroqua, Neillsville, and Wautoma.

After explaining the program to Nelson's management and employees, he outlined his problem and proposed solutions at a meeting in Tomah on October 13 of physicians, hospital administrators, and plant managers from the affected towns.

The company redesigned its health insurance plan to increase its deductibles and coinsurance while increasing the company's contribution toward the total cost of each employee's policy from 60% to 70%.

In addition, Nelson proposes to continue to seek competitive alternatives, work with other businesses to seek long-range solutions, assist employees in "comparison shopping" for healthcare by identifying the higher cost providers in the area of each plant, provide educational materials for employees on good nutrition, fitness and lifestyle, and to schedule continuing meetings with providers to openly discuss problems and seek better solutions.

Flowers outlined a 10-point program to assist employees and dependents contain their personal health care costs.

Those attending the conference, including SMS Past Presidents Russell F Lewis, MD, Marshfield, and Albert J Motzel Jr, MD, Waukesha, were in general agreement that the approach being used by Nelson Industries to contain its rising healthcare costs should be duplicated throughout the state of Wisconsin by similar actions and conferences between employers-employees and providers. ■

Milwaukee business studying healthcare cost strategy

Major decision makers in Milwaukee business and industry are studying vigorous measures to control and reduce healthcare costs through a group identified as the Greater Milwaukee Committee/Metropolitan Milwaukee Association of Commerce. Since May the GMC/MMAC has examined a wide variety of cost containment policies including:

. . . Merger, conversion or closure of several hospitals and regionalization of high cost services and technology;

. . . Creation of an independent statewide hospital authority (public utility) to regulate all hospital expenditures and centralize all planning for hospitals, physicians' offices, nursing homes, HMOs (Health Maintenance Organizations), and nonhospital clinics;

. . . Design new health benefit programs which employ strong cost containment measures within HMOs, IPAs (Indpendent Practice Associations), and PPOs (Preferred Provider Organizations);

. . . Strengthen utilization and peer review through some kind of PSRO-type organizations;

. . . Redesign the policies for long-term care of the elderly in Wisconsin; and

. . . Restudy medical education, sponsor cost containment seminars, and review all health facility and planning in Southeastern Wisconsin.

The principal goal of the GMC/MMAC activity is reported to be to "increase the influence of the strongest businessmen and women in SEW (Southeastern Wisconsin)" on matters affecting healthcare and to diminish the influence of providers." ■

DHSS undergoes consolidation

The Department of Health and Social Services (DHSS) has consolidated and realigned a number of state functions within it in order to deal with recent state and federal program funding cuts.

A **Division of Care and Treatment Facilities** has been created to manage the State's institutions for the care of the mentally ill and developmentally disabled. DHSS Secretary Donald Percy has appointed Burton Wagner as administrator of this new division.

Secondly, the **Division of Community Services** within DHSS has been redesigned to incorporate the formerly separate Division of Economic Assistance, the noninstitutional programs of the Division of Community Services and the fiscal operations related to these programs formerly housed in the Division of Management Services.

Former program bureaus of the Division of Community Services have been consolidated into two bureaus: the Bureau of Human Resources and the Bureau of Community Programs.

The Bureau of Human Resources will contain the former Bureaus on Aging and Children, Youth & Families as well as programs related to Refugee resettlement, Indian and Hispanic/Migrant liaison.

The Bureau of Community Programs will contain the former Bureaus of Developmental Disabilities, Mental Health, Alcohol and other Drug Abuse and Hearing Impaired. The Physical Disabilities Coordinator and Blind/Vision Impaired Coordinator will also be in this bureau.

Gerald A Berge has been appointed administrator of the newly consolidated Division of Community Services. ■

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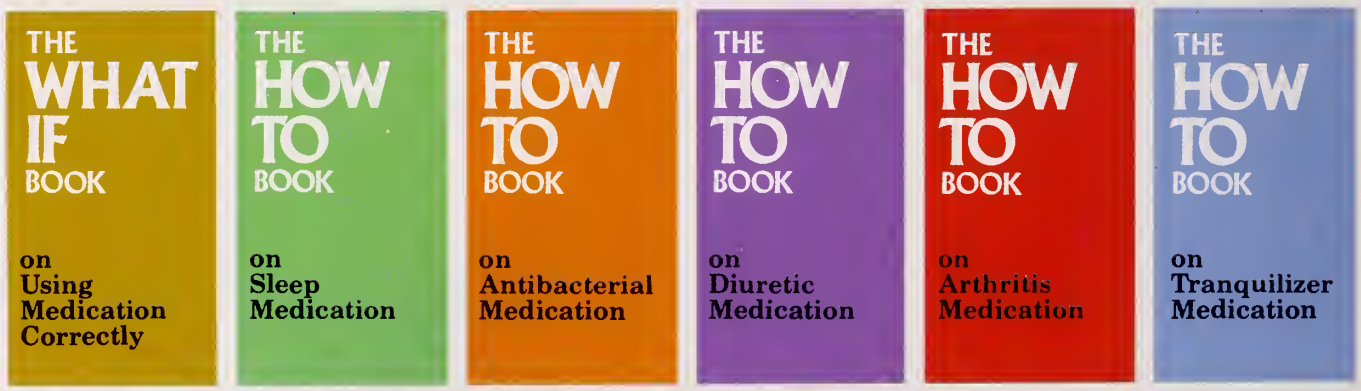

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MD-Business coalition formed in Sheboygan County

Physicians in the Sheboygan County Medical Society and local business representatives recently organized the Sheboygan County Physician-Business Health Care Coalition.

The purpose of the Coalition is three-fold: (1) to contain healthcare costs while preserving an acceptable level of healthcare delivery; (2) to develop and maintain a reasonable level of healthcare technology, and (3) to promote an adequate level of cooperation among healthcare professionals; healthcare institutions; governmental accrediting, and review agencies; business organizations, and the community at large.

Persons named to the Board of Directors were: Warren A Brauer, MD,* Dennis Colby, Associated Industries and Manufacturers; Ed Collins, Bemis Manufacturing; Ken Conger and Dan DeBaker, Kohler Company; Christopher Graf, MD;* John P Hermann, MD;* James D Horstmann, H C Prange Company; James B Kuplic, MD;* Robert Leicht, Eclipse Manufacturing; Marilyn McBride, Volrath Company; Howard A Mueller, MD,* Donald D Ohme, MD;* Charles Reff, Hayssen; and Stephen C Westcott, MD.*

The Board elected the following officers: Howard Mueller, MD*—President; Ed Collins—Vice President; Dan DeBaker—Secretary, and Donald Ohme, MD*—Treasurer.

The coalition has identified a number of healthcare problems it plans to address in the near future. Immediate plans include concerted efforts to expand the base of active memberships and to institute a series of informational meetings and projects. ■

DANE: At the Annual Meeting of the Dane County Medical Society held in October, Sandra L Osborn, MD,* Madison, was installed as the first woman president. Other officers are: Peter L Eichman, MD,* president-elect; Howard S Lubar, MD,* vice president; Kathryn P Nichol, MD,* secretary-treasurer; and Alwin E Schultz, MD,* past president. All the physicians are from Madison. The Nominating Committee's slate of candidates for delegates and alternate delegates to the State Medical Society (as reported in the October issue) was also approved.

WOOD: At the September meeting of the Wood County Medical Society, 28 members were present to hear Gerald C Kempthorne, MD,* Spring Green, president of the State Medical Society, speak on the Federal Trade Commission as it applies to medical practice. Also present were members of the Clark County Medical Society and the Wood County Medical Society Auxiliary. Sixteen new members were accepted into membership of the Society.

POLK: At the September meeting of the Polk County Medical Society, 15 members were present to meet two candidates for State Assembly, Mr. Harold Stauers and the incumbent, Mr David Paulson. Rick Reas from the State Medical Society's Physicians Alliance Division and Paul Jacobson, field consultant of PA Division spoke and answered questions on the new Medicaid payment system. John Simenstad, MD,* Osceola was the host for the evening. ■

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Specialty Societies

*Physician members of State Medical Society of Wisconsin

The American Society of Plastic and Reconstructive Surgeons, Inc, recently held its 51st Annual Scientific Meeting in conjunction with its affiliates, the Plastic Surgery Educational Foundation and the American Society of Maxillofacial Surgeons, in Honolulu, Hawaii. Ruedi P Gingrass, MD, Milwaukee, was elected president of the Plastic Surgery Educational Foundation during the meeting. He had served as the president-elect during 1981-82, vice president in 1980-81, and secretary from 1975-77. An associate professor and chairman of the Department of Plastic Surgery at the Medical College of Wisconsin, Milwaukee, Doctor Gingrass also is an assistant professor of oral surgery, Marquette University School of Dentistry.

Milwaukee Ophthalmological Society will hold its November meeting in Milwaukee on Tuesday, November 23. Gerald W Wadina, MD* Cudahy, president, will conduct the meeting. The speaker for the scientific program is Byron H Demorest, MD, Sacramento, Calif, and his topic is "What Ophthalmology Needs." Speakers for the remaining programs of the 1982-83 season also have been announced by Doctor Wadina. They are as follows: Jan 25, 1983: Herbert E Kaufman, MD, Chairman, Dept of Ophthalmology, Louisiana State University; February 22: David E Shoch, MD, Chairman, Dept of Ophthalmology, Northwestern Univeristy Medical School; March 25 or 26: Annual Meeting of State Medical Society of Wisconsin—program by Dept of Ophthalmology, MCW; April 26: Miles A Galin, MD, Dept of Ophthalmology, New York Medical College. For further information regarding meetings or membership, contact; Robert A Hyndiuk, MD,* Dept of Ophthalmology, The Medical College of Wisconsin, 8700 W Wisconsin Ave, Milwaukee, Wis 53226.

Society of Memorial Gynecologic Oncologists, at its annual meeting held in Montreal, Canada, installed Murray J Casey, MD, Cedarburg, as its new president. Members of the Society are former fellows and faculty of the Memorial Sloan-Kettering Cancer Center in New York. Doctor Casey is professor of obstetrics and gynecology at the University of Wisconsin Medical School. Prior to moving to Wisconsin in 1980, he was on the faculty of the University of Connecticut and he recently completed his term as president of the New England Association of Gynecologic Oncologists. ■

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Physician Briefs

*Physician members of State Medical Society of Wisconsin

Raymond J Rogers, MD,* Oconto, recently was honored for "50 Years of Active Practice" in medicine. He received a gift and plaque from the Marinette-Florence (Wisconsin) and Menominee (Michigan) county medical societies, of which at one time he had served as president. In 1940 he received an award from the Oconto Chamber of Commerce; in 1946, with grants from the W K Kellogg Foundation, he improved hospital laboratory services in the Upper Peninsula at Marinette General and Oconto Memorial hospitals; and in 1950 he organized the U P Cytology Laboratory, the first of its kind in Michigan. From 1956-1981, Doctor Rogers was pathologist and laboratory director at the former St Joseph Lloyd Hospital; St Francis Hospital in Escanaba, Mich; the Veterans Administration Hospital, Iron Mountain, Mich; Marinette General, and Oconto Memorial hospitals; and Door County Memorial Hospital in Sturgeon Bay. He graduated from Marquette University School of Medicine in 1932.

Mary C Meyer, MD, Green Bay, has joined the West Side Clinic, Green Bay, in the Department of Pediatrics. She graduated from Case Western Reserve University School of Medicine and served her internship and residency at Children's Memorial Hospital, Northwestern University, Chicago, Ill.

Mary E Nelson, MD, formerly of Milwaukee, has joined the medical staff of the Gundersen Clinic in La Crosse. Doctor Nelson graduated from the Medical College of Wisconsin, Milwaukee, and completed her internship and residency training at the Medical College of Wisconsin.

Vanee Songsiridej, MD,* an allergist graduate from Siriraj Medical School at Mahidol University, Bangkok, Thailand, has joined the medical staff of the Gundersen Clinic, La Crosse. She completed an internal medicine residency at St Joseph Hospital, Evanston, Ill, and completed a fellowship in allergy and clinical immunology at the University of Wisconsin in Madison.

John Downing, MD, recently joined the medical staff of Memorial Community Hospital in Edgerton. An ophthalmologist, Doctor Downing is associated with the Riverview Clinic in Janesville. He served his ophthalmology residency at Baylor Medical College in Houston, Tex.

Joseph J Mazza, MD,* Marshfield, recently attended the annual meeting of the American Society of Internal Medicine in Chicago. Doctor Mazza is president-elect of the Wisconsin Society of Internal Medicine and was a delegate at the annual meeting.

Roger A Bell, MD,* recently was elected president of Holy Family Hospital's medical staff, Manitowoc. He succeeds Robert D Bush, MD,* who served in that capacity the past two years. Carl C Kobelt, MD,* was named president-elect and Franz M Kraler, MD, secretary-treasurer.

Richard W Shropshire, MD,* Monona, recently was named vice speaker of the Congress of Delegates of the American Academy of Family Physicians. Doctor Shropshire, formerly on the staff of the Family Practice Department of the University of Wisconsin Medical School, is in full-time private family practice. He was the first family physician from Wisconsin to be elected to an AAFP office since 1968 and has served on various AAFP commissions and committees. He also served as president of the WAFP.

Daniel J McCarty, MD,* Milwaukee, professor and chairman of the Department of Medicine at the Medical College of Wisconsin, recently received three international awards for his work in rheumatology. He presented the Jan van Breemen Lectureship and received a gold medal from the Dutch Society of Rheumatologists; he presented the Highton Memorial Oration in New Zealand; and the Heberden Society in London, England, honored him and presented him with a gold medal. In addition to these honors, Doctor McCarty was recently appointed to the editorial board of the *Journal of the American Medical Association* (JAMA).

Leland C Pomainville, MD,* (right), Wisconsin Rapids, recently presented a plaque to Boyd Campbell (left) in memory of Doctor Pomainville's brother, Harold, who passed away in February 1980. Campbell is athletic director of Nekoosa High school. Doctor Pomainville is retiring and has donated medical equipment to area schools. Both the Pomainvilles participated in football in Nekoosa in the 1920s, with Harold being captain of the basketball team and Leland captain of the football team. (*Wisconsin Rapids Tribune* Photo)

Barry L Tulkki, MD, Eau Claire, recently joined the Eau Claire Health Cooperative. A graduate from the University of Minnesota Medical School, Doctor Tulkki completed his residency at the St Francis-Mayo Family Practice Center in La Crosse.

Susan L Turney, MD, Marshfield, recently became associated with the permanent medical staff of the Marshfield Clinic. She graduated from the University of Wisconsin Medical School, Madison, and completed her residency training at the Marshfield Clinic.

Paul A Kornaus, MD,* Sun Prairie, has joined the medical staff at the Sun Prairie Clinic. Doctor Kornaus graduated from the University of Wisconsin Medical School, Madison, and completed his family practice residency at the Cedar Rapids Family Practice Program in Cedar Rapids, Ia.

Christine L Uber, MD, Wisconsin Rapids, has joined the medical staff of Riverwood Clinic, SC. Doctor Uber graduated from the University of Wisconsin Medical School, Madison, and completed her residency in internal medicine at Methodist Hospital in Madison.

Darold A Treffert, MD,* Fond du Lac, recently was the featured speaker at a dinner honoring Sen Gary Goyke (D-Oshkosh). Senator Goyke was noted for his achievements and his work as chairman of the Wisconsin Council on Alcohol and Other Drug Abuse. Doctor Treffert had worked with the Senator while he chaired the Controlled Substances Board of Wisconsin.

Ed Vandenberg, MD, Washburn, recently joined the medical staff at the Bayfield County Medical Hospital. Doctor Vandenberg graduated from the University of Nebraska Medical Center where he also completed his residency. He worked at a Public Health Service Hospital in Kotzebue, Alaska; and was in private practice for two years in Nebraska prior to completing a family practice residency at St Mary's Hospital in Grand Junction, Colo.

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Jill Harman, MD, Sharon, recently opened her medical practice in Rosholt. Doctor Harman graduated from the University of Wisconsin Medical School, Madison, and completed her residency at St Luke's Hospital in Milwaukee.

John Larson, MD, Bloomer, has joined the Blue Diamond Family Practice Center in Bloomer. A graduate from the University of Wisconsin Medical School, Madison, Doctor Larson served his residency in Tacoma, Wash. He also served as director of the Family Practice Residency Program at Martin Army Hospital in Fort Benning, Ga. He is on the medical staff at Bloomer Community Memorial Hospital.

Patricia Blochowiak, MD, Green Bay, recently became associated with the Dousman Clinic, Green Bay. Doctor Blochowiak graduated from the University of Wisconsin Medical School, Madison, and completed her family practice residency at Deaconess Hospital, Milwaukee.

Fred W Fletcher, MD,* Eagle River, a member of the Eagle River Memorial Hospital medical staff since 1975, recently took a leave of absence to seek further education in the nuclear, ultrasound, and 2-D echocardiography field. He is a graduate of the University of Iowa School of Medicine and served residencies in Iowa and California prior to joining the Marshfield Clinic and St Joseph's Hospital medical staff where he had practiced for 12 years.

Thomas R Flygt, MD,* Baraboo, recently opened his medical practice in Baraboo. Doctor Flygt graduated from Johns Hopkins University Medical School and served his residency at the Indiana University Medical Center. He is a diplomate of the American Board of Internal Medicine.

James Hanusa, MD, Iola, recently became associated with Iola Clinic medical staff. Doctor Hanusa graduated from the University of Wisconsin Medical School, Madison, and completed his residency at Bexar County Hospital in San Antonio, Tex.

John E Walz, MD, Stanley, recently opened his medical practice in Stanley. Doctor Walz graduated from the Medical College of Wisconsin, Milwaukee, and completed his surgical residency at St Joseph's Hospital in Milwaukee. He also served in the United States Navy for four years.

James J Buth, MD,* Mequon, and **Peter T Geiss, MD,*** Muskego, recently opened their medical practice in the Medical Associates of Muskego Ltd clinic. They are members of the medical staff of Waukesha Memorial Hospital and are former assistant professors in the Department of Internal Medicine of St Louis University Medical School. Doctor Buth graduated from St Louis University Medical School and served his internship and residency at St Louis University Hospitals. He was the assistant director of emergency services at St Louis City Hospital. Doctor Geiss also graduated from St Louis University Medical School and completed his residency at St Louis University Hospital. ■

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Obituaries

Carroll W Osgood, MD, 83, Wauwatosa, died Aug 12, 1982 in Wauwatosa. Born Aug 16, 1898 in Sturgeon Bay, Doctor Osgood graduated from the University of Wisconsin Medical School, Madison, in 1927. His internship was completed at Philadelphia General Hospital in Pennsylvania. Doctor Osgood was on the medical staff of the Milwaukee Psychiatric Hospital for over 42 years. He was a member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association. Surviving are his widow, Mildred; and two sons, Thomas and Charles, and a daughter, Mary.

Paul J Purtell, MD, 79, Pompano Beach, FL, former Milwaukee physician, died Sept 2, 1982 in Milwaukee. Born Aug 17, 1903 in Milwaukee, Doctor Purtell graduated from the University of Marquette School of Medicine in 1930 and served his internship at St Agnes Hospital in Fond du Lac. He was a member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association. Surviving are his widow, Irene; and four daughters, Patricia Julien, Barbara Mathie, Margueritte Shields, and Sharon Steinmetz.

David J Noll, MD, 56, Verona, died Sept 15, 1982 in Madison. Born Nov 9, 1925 in Alma, Doctor Noll graduated from the University of Wisconsin Medical School, Madison, in 1949 and served his internship and residency at University Hospitals, Oklahoma City, Okla. Doctor Noll served in the United States Air Force during the Korean War. He had been in medical practice in Madison since 1957. Doctor Noll was a member of the medical staff of St Mary's Hospital Medical Center and had also served as chief-of-staff. He had been a member of the board of directors of Wisconsin Health Care Review, Inc, (WHCRI) from 1974-1977. He was a member of the Wisconsin Professional Review Organization (WISPRO) serving as chairman of the South Central District Review Council; chariman of the Quality Assurance Committee; and also as a medical consultant of the Board of Directors. He was a member of Dane County Medical Society, State Medical Society of Wisconsin, and American Medical Association. Surviving are his widow, Eva; seven daughters, Mrs Paul (Christine) Seitz and Sarah, New York City; Amy, Madison; Monica, Verona; Mrs David (Laurie) Calhoun, Madison; and Nancy and Jessica, both of Verona; four sons, Tracy, Garland, Tex; Tim, Mount Pleasant, Mich; Tony, Cuba City, and Peter of Verona.

Arthur H Thorstensen, MD, 81, Milwaukee, died Sept 17, 1982 in Milwaukee. Born Oct 2, 1900 in Milwaukee, Doctor Thorstensen graduated from Northwestern University School of Medicine and served his internship at Deaconess Hospital in Milwaukee. He practiced in the Milwaukee area for over 42 years and had been a member of the medical staff of St Joseph's Hospital, Milwaukee. Surviving are his widow, Lydia; two daughters, Joan Wilkinson, Santa Ana, Calif; Suzanne Gardner, Longmont, Colo; and one son, Rev Arthur H Thorstensen of Ashby, Minn.

John V Berger Jr, MD, 69, Madison, died Sept 18, 1982 in Madison. Born Sept 3, 1913 in Berwyn, Ill, Doctor Berger graduated from the University of Wisconsin Medical School, Madison, in 1938 and served his internship and residency at Research Hospital in Kansas City, Mo. He served in the United States Army Air Force during World War II. Doctor Berger was a member of the Davis-Duehr Eye Clinic from 1953 until his retirement in 1979. He was a Clinical Professor Emeritus at the University of Wisconsin Medical School, Madison. Doctor Berger was a member of the Dane County Medical Society, State Medical Society of Wisconsin, and American Medical Association. Surviving are his widow, Janet; three daughters, Barbara Brand, Long Island, New York; Margaret Berger, Cambridge, Mass; Laura Berger, Madison, and a grandson, Gordon Brand.

Jack J (Bluie) Saxe, MD, 66, Portage, died Sept 18, 1982 in Madison. Born Aug 23, 1916, Doctor Saxe graduated from Northwestern University School of Medicine in 1942 and served his internship at Milwaukee County General Hospital. He had practiced in the Portage area until his retirement in December 1981. Doctor Saxe served in the United States Army from 1943-1946. He was a member of the Columbia-Marquette-Adams County Medical Society, State Medical Society of Wisconsin, and American Medical Association. Surviving are his widow, Eleanor; two sons, John G, Darlington; Patrick W, Alliance, Neb; and three daughters, Mrs Edward (Alice) Lockman, Randolph, NJ; Ms Susie Saxe, Chesterton, Ind; and Ms Kitsi E Saxe of Madison.

James J Clark, MD, 80, Janesville, died Sept 23, 1982 in Janesville. Born Mar 6, 1902 in Janesville, Doctor Clark graduated from the University of Wisconsin Medical School, Madison, in 1932 and practiced for several years in Virginia until retiring in 1970. He served in the United States Navy during World War II. Surviving are three brothers, Clement, Seagrit, NJ; Maurice, McHenry, Ill; and Edmund of Glen Ellyn, Ill. ■

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J-9043-4 July 1981

In the treatment of insomnia

Good mornings start with restful nights.

Dalmane *(flurazepam HCl/Roche)* patients fall asleep faster, sleep longer and seldom awaken with morning hangover.

Feeling well rested in the morning usually means having slept well the night before. And for insomniac patients receiving hypnotic therapy, a good morning also means awakening with few side effects from their medication. Many physicians choose Dalmane for their patients who suffer from insomnia for this very reason.

Aside from enabling patients to fall asleep more quickly and sleep longer, Dalmane seldom causes morning hangover. Most Dalmane patients feel alert and refreshed when they awaken. In 53 paired-night clinical studies comparing Dalmane and placebo in 2010 insomniac patients with a variety of secondary diagnoses, most Dalmane patients awakened more alert and refreshed, and less groggy and drowsy, than on nights when they had taken only placebo.[1] In a double-blind crossover study of 42 patients in private practice, approximately three times as many patients reported feeling refreshed and alert upon awakening after a night on Dalmane (flurazepam/Roche) compared to placebo nights.[2] This difference was highly significant ($p<0.001$). And a retrospective study of 2542 hospitalized patients who received Dalmane revealed only a 3.1% incidence of side effects.[3]

While residual effects from Dalmane therapy are infrequent, patients should be cautioned about drinking alcohol, driving or operating hazardous machinery after ingesting the drug.

Efficacy and safety in a broad range of patient types.

Over 2000 clinical trials involving more than 10,000 patients have shown that Dalmane patients fall asleep sooner, sleep longer and experience fewer nocturnal awakenings.[4] The safety and efficacy of Dalmane have been demonstrated in medical and surgical hospitalized patients, in patients seen in office practice and in elderly patients.[5-8] Since the risk of oversedation, dizziness, confu-

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sion and/or ataxia increases with larger doses in the elderly, it is recommended that the dosage be limited to 15 mg.

Moreover, the efficacy and safety of Dalmane for the treatment of insomnia have been demonstrated in thousands of patients with a variety of primary medical conditions, including cardiovascular, neuropsychiatric, endocrine-metabolic, gastrointestinal, genitourinary, respiratory and musculoskeletal disorders.[1] Dalmane (flurazepam HCl/Roche) is contraindicated in pregnancy and in patients hypersensitive to the drug.

Avoids rebound insomnia upon discontinuation.

Rebound insomnia—a worsening of sleep beyond pretherapy levels after drug discontinuation—has been reported as a potential clinical problem with some hypnotics.[9,10] However, this problem has not been reported with Dalmane. In eight out of eight sleep laboratory studies, there were no reports of rebound insomnia.[11] When you prescribe Dalmane, you can be confident of efficacy that enhances therapeutic progress. Your insomniac patients can be assured of a restful night, night after night—a good start for a good morning.

References: 1. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **2.** Zimmerman AM: *Curr Ther Res 13*:18-22, Jan 1971. **3.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977. **4.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **5.** Meyer JA, Kurland KZ: *Milit Med 138*:471-474, Aug 1973. **6.** Feffer HL, Gibbons B: *Med Times 101*(8):130-135, Aug 1973. **7.** Jacobson A *et al*: *Psychophysiology 7*:345, Sep 1970. **8.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. **9.** Kales A, Scharf MB, Kales JD: *Science 201*:1039-1041, Sep 1978. **10.** Kales A *et al*: *JAMA 241*:1692-1695, Apr 1979. **11.** Monti JM: *Methods Find Exp Clin Pharmacol 3*(5):303-326, 1981.

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Please see following page for summary of product information.

Dalmane®Ⓝ

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15-mg/30-mg capsules

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruntus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

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Physicians Exchange

Obstetrics-Gynecology. Position available at the Racine Medical Clinic, a progressive cluster corporation of 25 physicians. Excellent benefits, unlimited earnings and a fulfilling practice offered. Please contact: Roger D Lacock, Administrator, Racine Medical Clinic, 5625 Washington Ave, Racine, Wis 53406; ph 414/886-5000. 9tfn/82

Family Physician or Internist with family practice interest to join physician in well established practice in southeastern Wisconsin. Excellent hospital with specialty consultants available. Educational and recreational facilities abundant in area. Opportunity for immediate substantial income, early corporation membership and eventual purchase of practice to qualified individual. Contact Dept 510 in care of the Journal. 10-12/82

Kurten Medical Group is expanding, and offers excellent opportunities in orthopedic surgery, oncology, pulmonary medicine, gastroenterology, and OB/GYN. We have an innovative group structure which allows maximum flexibility and the security of a strong group environment. We presently have 23 physicians. Please contact Stephen L Wagner, Administrator, Kurten Medical Group, 2405 Northwestern Ave, Racine, Wis 53404; ph 414/632-7521. 11tfn/82

Internist—29, Board certified, recently completed chief residency seeking suitable Primary Care Practice opportunity in metropolitan Milwaukee area in solo, partnership, group or hospital-based positions. Please reply to N Ravi, MD, 2300 Lincoln Park West, #917, Chicago, Ill 60614 or call 312/248-4030. p11/82

Excellent opportunity to practice general internal medicine and/or gastroenterology by assuming part of a retiring physician's practice in a 4-man group. Salary negotiable. Excellent fringe benefits. Send CV to Administrator, Cathedral Square Medical, 525 E Wells, Milwaukee, Wisconsin 53202. 10-11/82

Wanted. An internist interested in cardiology, an orthopedist and a psychiatrist. Work part-time (20-35 hours/week) at the Bureau of Social Security Disability Insurance, 310 Price Place, Madison, Wisconsin 53705. If interested, please write or telephone George H Handy, MD, PO Box 7623, Madison, Wis 53707; ph 608/266-1989. 11-12/82

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Plastic Surgeon and Dermatologist positions available with an 18 member multispecialty group corporate practice. Modern clinic facility in Northeastern Wisconsin city of 100,000 enjoying a healthy and stable economy. Excellent recreational, educational, hospital, civic advantages. Please call collect or write: W J Mommaerts, Clinic Manager, West Side Clinic, sc, 1551 Dousman St, Green Bay, Wis 54303; ph 414/494-5611. 9-12/82

Family Practitioner needed for primary care, ten physician, multispecialty clinic in northeast Wisconsin. Excellent, well equipped hospitals with 900 beds. Competitive salary and benefits. Contact: F T Mansell, MD, 1751 Deckner Ave, Green Bay Wis 54302; ph 414/468-5621. 11tfn/82

Orthopedic Surgeon wanted to join multispecialty group consisting of 58 physicians located in west central Wisconsin, a city of 50,000 with a state University of 12,000—90 miles east of the Twin Cities. Excellent opportunity for a stimulating practice in a pleasant environment. If interested contact Donald R Griffith, MD, Medical Director, Midelfort Clinic, Ltd, 733 West Claire-mont Ave, Eau Claire, Wis 54702; or call 715/839-5222. 11-12/82;1/83

Family Practice opportunity available to join a long-established, four-physician family practice group in south central Wisconsin. Salary basis initially, leading to full corporate membership. Numerous fringe benefits. Pleasant community. Contact: Chad Burchardt, Business Manager, Medical Associates of Beaver Dam, SC, 1200 N Center St, Beaver Dam, Wis 53916; ph 414/887-7101. 10-12/82

Okauchee, Wis. Thirty miles west of Milwaukee. An attractive lake community needs professional services. Our growing population supports one public and two private grade schools. Our community presents an excellent opportunity for a physician to build a rewarding practice. If you are interested, write to: Okauchee Area Business Association, PO Box 35, Okauchee, Wis 53069. 10-12/82

MARSHFIELD CLINIC, a major multispecialty referral center, is seeking family practitioners for outpatient satellites. Rural location in beautiful central Wisconsin. Excellent salary and fringe benefits. Must be Board certified/eligible. Send curriculum vitae to Frederic P Wesbrook, MD, 1000 N Oak Ave, Marshfield, Wis 54449. 11-12/82

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Physicians Exchange

continued

Doctors needed—in Wisconsin. All specialties and all locations. For confidential information, mail your CV to: Medicus, 1525 Wisconsin Ave, Grafton, WI 53024. 6tfn/82

Wausau Medical Center, SC, a 50-physician multispecialty group has openings for physicians in the following specialties: *OB/GYN, Otolaryngology, Cardiology, Neuroradiology,* and *General Surgery.* Competitive first-year salary, incentive plan thereafter. Comprehensive fringe benefits. New facility near new hospital. Located in beautiful, quiet, central Wisconsin, metropolitan area of 65,000. Recreational opportunities abundant. For more information contact: K L Day, MD, Wausau Medical Center, SC, 2727 Plaza Drive, Wausau, Wis 54401, or call collect 715/847-3351. 6tfn/82

Family Practice position available with an 18-member multispecialty group corporate practice. Modern clinic facility in Northeastern Wisconsin city of 100,000 enjoying a healthy and stable economy. Excellent recreational, educational, hospital, civic advantages. Please call collect or write: W J Mommaerts, Clinic Manager, West Side Clinic, SC, 1551 Dousman St, Green Bay, Wis 54303; ph 414/494-5611. 8-11/82

Family Physician to join three Board certified family physicians in a young and growing medical practice in Central Minnesota. The practice is orientated toward Family Practice Medicine and located centrally in the state with quick access to the Minneapolis-St Paul area. Both practices are a short distance from the St Cloud area, and our physicians use the St Cloud Hospital for hospitalization of their patients. Cultural and recreational activities are abundant in this area of Minnesota. The salary and fringe benefits are open and negotiable. If interested, please contact Thomas J Newton, MD, Medical Director, or contact Daryl G Mathews, Administrator, at either the St Joseph or Cold Spring Medical Clinics, 26 North Red River Ave, Cold Spring, Minnesota 56320; or call collect (612) 685-8641 or (612) 363-7765 in St Joseph, Minnesota. 7-10/82

Internist—Board certified, seeks part-time or full-time positions in clinics, emergency room coverage, locum tenens, etc, in metropolitan Milwaukee area. Available immediately. Contact Dept 511 in care of the Journal. p11/82

U S Air Force Medical Corps currently is accepting applications for physicians in the following specialties: *Surgery (all specialties), Obstetrics/Gynecology, Otorhinolaryngology, Anesthesiology, Urology, Rheumatology, Neurology, Psychiatry.* For further information call collect, MSGT Charles Brown Jr, 414/258-2480. 11-12/82

Surgeon with general vascular training, Ophthalmologist, and ENT, to join a progressive multispecialty group of 17 physicians consisting of General/Family Medicine, General Surgery, Internal Medicine, OB-GYN, Ophthalmology, Orthopaedic Surgeon, Pediatrics/Adolescent Medicine, and Radiology. Subspecialties include: Pathology, Vascular Surgery, Cardiovascular Diseases, Gastroenterology and Endoscopy. We are located in a fast growing, scenic, lake country area between Milwaukee and Madison and can offer excellent hospital, schools, and recreational facilities. Full fringe benefit package. Contact: James F Dowd, Admin, Wilkinson Clinic SC, 915 East Summit Ave, Oconomowoc, Wis 53066; ph 414/567-4433. 10tfn/82

Experienced middle-aged family nurse practitioner seeks practice opportunity in Milwaukee or surrounding area. Desire general primary care with adults and children plus opportunity for health education, weight reduction, and stress management programs for individuals and groups. Open to part-time until practice builds. For vitae/interview, contact J D Wida, MSN, 414/962-3958. 11-12/82

La Crosse—Dynamic, 52-physician, multispecialty clinic is recruiting in the following specialties: *General/Vascular Surgery, Neurology, Family Practice, Neonatology, Ophthalmology.* Strong in primary and secondary care, we have six active satellite clinics. Modern 350-bed hospital with CT scanner and medical staff of 92 MDs, including neurosurgeon, immediately adjacent to clinic building. La Crosse is a progressive, family-oriented city of 50,000 in the beautiful Mississippi River Valley with a medical referral area of greater than 200,000. Exceptional cultural, educational, and recreational opportunities locally. Contact: P S Shultz, MD, Medical Director, Skemp-Grandview-La Crosse Clinic, 815 S 10th St, La Crosse, Wis 54601; ph 608/782-9760. 11-12/82

Family Practitioner and occupational medicine specialist needed to join multispecialty group of 33 physicians dedicated to primary care in East Central Wisconsin community. City population 38,000, drawing area 100,000. Attractive income arrangements, association membership possible after one year, pension and profit sharing, extensive fringe benefits. Contact R B Windsor, MD, 1011 North 8th St, Sheboygan Wis 53081; ph 414/457-4461 10tfn/82

Ideal practice opportunities for Family Practice and Internal Medicine in scenic Kettle Moraine area, Plymouth, Wisconsin. Less than one hour drive from Milwaukee, 60 miles from Green Bay. Service community of 20,000. Modern JCAH hospital and 60-bed nursing home. Family-oriented community with good industrial base. Please contact: Peter R Strub, Coordinator, Physician Recruitment Committee, Plymouth Hospital, Inc, 901 Reed St, Plymouth, Wis 53703; ph 414/893-1771. 8/82*

Locum Tenens opportunity available 9/30/82. Temporary full time position to carry patient load of exiting physician. Potential for permanent practice if desired. Excellent pay arrangements and liability insurance. If interested please contact: Norman C Schroeder, MD, Park Medical Center, Ltd, 601 North 8th St, Manitowoc, Wis 54420; ph 414/682-4646. 9-11/82

Podiatrist. Surgically and clinically trained podiatrist seeks office-sharing or rental agreement with MD. Racine area preferred but other locations possible. All serious inquiries invited. Dr Martin Marks, 2725 Glen Flora, Apt 401, Waukegan, IL 60085; ph 312/244-9468. p11/82

Family Physician for Locum Tenens. Experienced Board certified family physician for 9 years on the full time faculty of the University of Wisconsin Medical School, available for Locum Tenens, all areas of Wisconsin. Contact: Rudolph C Hecht, MD, 312 Newcastle Way, Madison, Wis 53704; ph (home) 608/249-5201. 10-12/82

Family Practitioner—Immediate need to associate with busy, Board certified family practitioner in Tomah. Modern clinic, 57-bed local hospital, and formal association with 52-physician multispecialty clinic in La Crosse. Tomah is an active, growing community of 7,000 with a medical service area of 20,000. Contact: P S Shultz, MD, Medical Director, Skemp-Grandview-La Crosse Clinic, 815 S 10th St, La Crosse, Wis 54601; ph 608/782-9760. 11-12/82

OB/GYN Specialists. Enjoy the security of group practice with the freedom of independent practice. If you are Board certified or Board eligible in OB/GYN, we have an interesting opportunity for you. Two specialists are needed immediately to form an independent OB/GYN practice in a very desirable Northern Wisconsin community with a drawing population of 70,000. Active practice assured. All major specialists available for consultation. Business and technical advice will be provided. Outstanding personal benefit programs available. Good income potential. New 35 million dollar hospital. For further information write: Administrator, PO Box 1646, Wausau, Wisconsin 54401. 9-11/82

Family Practice Physician to share fully equipped medical office in central Wisconsin city. Opportunity for partnership and eventual purchase of practice. Excellent recreational, educational, hospital, and civic advantages. Send curriculum vitae to Dept 503 in care of the Journal. 6tfn/82

Family Physician to join our group of six Board certified family practitioners and Board certified general surgeon. Liberal vacation and educational allowances. Competitive salary first year with incentive bonus, and full membership after one year. Blue Earth is a farming town of 4000 in Southern Minnesota with a drawing area of 25,000. 35-bed hospital with adjoining clinic facilities. Complete opportunity for an aggressive young family physician. Please contact Marjeane Werner or Thomas E Watts, MD, Blue Earth Medical Center, Ltd, 520 South Galbraith, Blue Earth, Minn 56013; ph 507/526-7371. 8-12/82; 1/83

Adult Psychiatrist to join well established group in a community of 50,000 with large referral area. Two excellent hospitals, University, and industrial area. Salary—open. Excellent benefits. For further information contact: J M Tobin, MD, Northwest Psychiatric Clinic, Eau Claire, Wis 54702; ph 715/834-2751. 8-12/82; 1/83

The Racine Medical Clinic, a progressive cluster corporation of 25 physicians, is currently seeking an orthopedic surgeon and an invasive cardiologist. Full benefits, unlimited earnings and a full and exciting practice are offered. Please contact: Roger D Lacock, Administrator, Racine Medical Clinic, 5625 Washington Ave, Racine, WI 53406; ph 414/886-5000. 1tfn/82

Locum tenens services. Wisconsin-licensed family physician available and also needed. Our physicians do office, hospital, emergency room and OB work. Call or write: INTERHEALTH, 5695 Merry Lane, Excelsior, MN 55331; ph 612/474-4372. 10-12/82;1-4/83

Family Physician or Internist to join three-man family and general practice group in the heart of North Central Wisconsin vacationland. First year guaranteed salary. Numerous fringe benefits. Clinic across from hospital. Send CV to: O M Francisco, MD, 221 E Washington Ave, Tomahawk, Wis 54487; ph 715/453-2147. 5tfn/82

Medical Facilities

Medical office space for lease. New Swiss chalet style building in fast growing community. Needs family practitioner, pediatrician, etc. Building has dentist and pharmacy. Very reasonably priced in Waukesha County near expressway. Info: call 414/781-1155. 7tfn/82

Two-story medical office building for sale, New London, Wis, for single or group practice. Fully equipped and ready for occupancy Nov 1, 1982. Reason for vacancy—physician retiring from very active 50-year practice. First floor includes four examining rooms, lab and x-ray facilities, large waiting room, and bookkeeping office. Call 414/982-2144 Monday through Thursday; 414/982-3615, evenings and weekend. 10-12/82

Office furniture for sale. Metal desk and credenza. One swivel and two contemporary chairs with floor lamp. Call 414/332-4241 after 4:00 pm. g10tfn/82

Established solo practice in internal medicine for sale. Available immediately. Located in Milwaukee area. For information call 414/332-9006 or contact Dept 509 in care of the Journal. g9/82

Eye, ear, nose and throat physician retiring. Has equipment with trial lenses in cabinet—Greens plus phoroptor. B & L Hydraulic chair. Ritter ENT cabinet plus instruments, frames, plus display, mirrors etc. Contact Joseph J Grimm, MD, 921½ Milwaukee Ave, South Milwaukee, Wis 53172; ph 414/762-3730. 11/82

For Sale: Surgical, dental and plastic surgery instruments, fiberoptics, etc. In addition, office equipment, autoclave, journals, files, and furniture. Retired from practice. Contact: John P Docktor, MD, DDS, 161 West Wisconsin Ave, Milwaukee, Wis 53203; ph 414/271-4810 or 414/377-2537. 11/82

Medical equipment and office furniture for sale. Contact telephone number 414/645-6695 or call evenings after 6:00 pm 414/781-4420. 11/82

Miscellaneous

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Marketing strategies for private practice. A new workshop for physicians offered by AMA at its headquarters in Chicago, November 5, December 10, 1982 and January 28, 1983. Session includes an update on major health care trends, improving referral patterns, enhancing patient satisfaction, and development of a coordinated marketing plan for solo physicians and small groups. Fees are $150 for members and $185 for nonmembers. Sessions limited to 30 registrants. Contact Dept of Practice Management, AMA Headquarters, 535 North Dearborn St, Chicago, Ill 60610; phone 312/751-6000; for brochure describing course. g10-12/82

PLACEMENT SERVICES

Opportunity Placement Register and **Physician Placement Register.** August/September issues now available from the AMA. The OPR contains hundreds of medical practice openings throughout the US. The PPR lists physicians seeking practice locations. Also available is a brochure, *Preparing a Professional Vitae*, designed to aid physicians in resume writing. To get a complimentary copy of any of these publications, write Physicians' Placement Service, AMA Headquarters, 535 North Dearborn St, Chicago, Ill 60610, or phone 312/751-6282. g10tfn/82

ANNOUNCEMENTS

NEW POLICY

The Editorial Board has established a policy for publication of announcements which involve referral of patients for designated studies or surveys, specialized healthcare services offered, practice management programs, and the like. These announcements will be accepted, at the discretion of the editors, at the following rate: $3.00 per line (average nine words per line).

Bookshelf

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School and by others who are particularly qualified. Most books here listed will be available on loan from the Medical Library Service, 1305 Linden Drive, Madison, Wisconsin 53706; tel. 608/262-6594.

Goodbye Blues: Breaking the Tranquilizer Habit the Natural Way. By Bernard Green, PhD. McGraw-Hill Book Company, 1221 Avenue of the Americas, New York, NY 10020. 1982. Pp 173. Price: $5.95.

Sourcebook on Food and Nutrition—Third Edition. Edited by Ioannis S Scarpa, PhD; Helen C Kiefer, MD, PhD; and Rita Tatum. Marquis Who's Who, Inc, 200 East Ohio St, Chicago, IL 60611. 1982. Pp 550.

Principles of Clinical Electrocardiography. By M J Goldman. Lange Medical Publications, Drawer L, Los Altos, Calif 94022. 1982. Pp 438. Price: $15.

Correlative Neuroanatomy & Functional Neurology. By J G Chusid. Lange Medical Publications, Drawer L, Los Altos, Calif 94022. 1982. Pp 476. Price: $15.

Peptic Ulcer. By Morton I Grossman. Year Book Medical Publishers, 35 East Wacker Dr, Chicago, IL 60601. Pp 179. Price: $25.50.

Current Obstetric & Gynecologic Diagnosis & Treatment, 4th edition. Edited by Ralph C Benson, MD. Lange Medical Publications, Drawer L, Los Altos, Calif 94022. 1982. Pp 1038. Price: $25.

Schneierson's Atlas of Diagnostic Microbiology. Edited by Edward J Bottone, PhD; Roland Girolami, PhD; John M Stamm, MSc. Abbott Laboratories, Abbott Park, North Chicago, IL 60064. 1982. Price: $2.75.

The Complete Professional Corporation Desk Book. By Harry V Lamon Jr and J Alston Thompson Jr. Prentice-Hall, Inc, Englewood Cliffs, NJ 07632. 1982. Pp 754. Price: $49.95.

Catalog of Aids for the Disabled. By Nancy & Jack Kreisler. McGraw-Hill Book Company, 1221 Avenue of the Americas, New York, NY 10020. 1982. Pp: 246. Price: $24.95.

Cancer and Field. By T Imaizum. Maruzen Co, Ltd, PO Box 5050, Tokyo International 100-31 Japan. 1982. Pp 115.

Clinical Ethics. By Albert R Jonsen, PhD; Mark Siegler, MD; William J Winslade, PhD, JD. Macmillan Publishing Co, Inc, 200D Brown St, Riverside, NJ 08370. 1982 Pp 183. Price: $15.95.

Incorporating the Professional Practice, Third Edition. By George E Ray. Prentice-Hall, Inc, Englewood Cliffs, NJ 07632. 1982. Pp 264. Price: $39.95.

China Report. Edited by John R Grahman, MD. Professional Seminar Consultants, Inc, 3194 Lawson Blvd, Oceanside, NY 11572. Pp 192. ■

MEMBERSHIP FACTS

ARE YOU A MEMBER of the State Medical Society of Wisconsin, or do you know someone who isn't? Whether you're just starting medical school, maintain a full-time practice, or are retired, SMS has a membership classification to fit your individual needs. Election to membership by the County Medical Society in which your principal place of practice is located carries with it membership in the State Medical Society of Wisconsin and, if you wish, the American Medical Association. If you qualify for resident membership at the time of your election, your membership dues are greatly reduced. This may also qualify you for reduced dues the first two years of your practice. Dues for regular membership in 1983 are $430 for SMS, $315 for AMA, and county society dues vary. A more detailed listing of SMS membership classifications and their corresponding dues follows:

State Medical Society of Wisconsin

DESCRIPTION OF MEMBERSHIP CLASSIFICATIONS

Regular: Member in active practice. Some are regular members that have reduced SMS and/or AMA dues because they are new practitioners (first year or two out of residency).

Resident: Physician who at January 1 of dues year is in an approved training program as a hospital resident or research fellow who is licensed to practice medicine and surgery in Wisconsin.

Military Service: Members who are serving in the U.S. armed forces (generally not to exceed five years).

Associate: Member whose dues are waived because of illness or financial hardship. This classification is temporary and is reviewed on an annual basis.

Life: Member who has held membership in a state medical society for 50 years or is a Past President of the State Medical Society of Wisconsin.

Honorary: Member who was named by the Board of Directors in recognition of long and distinguished service to the cause of medicine.

Retired: Member who has completely retired from practice (works less than 240 hours per year). All dues are waived unless county society indicates they wish to charge county dues.

Part-time Practice: Physician, regardless of age, who practices 1,000 hours or less during the calendar year but does not qualify for retired membership.

Over Age 70: Member in active practice who is over 70 years of age as of January 1.

Candidate: Member attending a medical school in Wisconsin or fulfilling a postgraduate obligation prior to eligibility for licensure.

Scientific Fellow: Member who is engaged in teaching one or more of the basic sciences at an accredited college or university, and not holding the degree of Doctor of Medicine or Osteopathy.

Emeritus: Retired members who have chosen not to renew their license.

1983 DUES AMOUNTS FOR THESE CLASSIFICATIONS

	SMS	AMA	COUNTY
Regular	$430	$315	Normal County Dues
Resident	43	45	Varies
Military Service	-0-	315 or 45	-0-
Associate	-0-	-0-	-0-
Life	-0-	-0-*	-0-
Honorary	-0-	-0-*	-0-
Retired	-0-	-0-*	-0-
Part-time Practice	215	315*	Normal County Dues
Over Age 70	215	-0-*	Normal County Dues
Scientific Fellow	-0-	-0-	
Emeritus	-0-	-0-*	
Candidate—			
Freshman Year Medical Student	-0-	15	Varies
Sophomore and Succeeding Medical Student Years	10	15	Varies
Postgraduate—One	10	45	Varies

*Due to recent policy changes by the AMA, future exemptions from AMA dues will be given to those physicians who are over 70 years of age *and* are retired from practice or practice 1000 hours or less a year.

State Society dues are prorated on a monthly basis for those elected to membership July 1 through September 30. Those elected after September 30 have no dues payable for the balance of the year in which they are elected. AMA dues follow the same pattern except prorating is on a semiannual basis rather than monthly basis.

13 MONTHS FOR THE PRICE OF 12!

In light of the change in membership policy allowing physicians to join their county and state societies and the AMA, or just their county and state societies, physicians are encouraged to join organized medicine now. Regular membership dues for 1983 are: $430 for SMS, $315 for AMA, and county society dues vary. However, physicians who join now will not pay any dues for the balance of 1982. That's 13 months for the price of 12! Membership applications may be obtained by contacting the secretary of your county medical society or by calling the Membership Department at the State Medical Society offices in Madison at 608/257-6781 or toll free: 800/362-9080. ■

Meetings/CME Courses

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is a nominal charge for listing of Continuing Medical Education courses at the following rates: 50¢ per word, with a minimum charge of $20.00 per listing. BOXED LISTINGS: $32.00 per column inch. Listings of other scientific meetings will be included at the discretion of the editors. COPY DEADLINE for listings is tenth of the month preceding the month of publication; e.g., copy for the August issue is due by July 10. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 800/362-9080. For listing of other meetings see the Special Issue of the Journal of the American Medical Association: Continuing Education Courses for Physicians for period Sept 1, 1982 through Aug 31, 1983.

WISCONSIN

DECEMBER 2, 1982: *Recent Advances in Medical Therapeutics*, Madison. Sponsored by Madison General Hospital. Category 1; AAFP prescribed 5¼ hours. Fee: $25. Info: Howard B Christensen, CME, 202 South Park St, Madison, Wis 53715; ph 608/267-6386.

DECEMBER 3, 1982: *Obsessive/Compulsive Neurosis & Phobic Reactions,* at Mendota Mental Health Institute, Madison. Presented by Harold Esler, PhD and Irene Sarkissian, RN, MA, Midwest Psychoanalytic Institute. Contact Training Dept, Mendota Mental Health Institute, 301 Troy Drive, Madison, Wis 53704; phone 608/244-2411.

DECEMBER 3-4, 1982: *2nd Annual Coronary Artery Disease Update,* Madison. Sponsored by University of Wisconsin School of Medicine, Dept of Medicine, Division of Cardiology and Departments of Surgery, Division of Thoracic and Cardiovascular Surgery; and University of Wisconsin-Extension, Dept of Continuing Medical Education. AMA Category 1; AOA Category 2-D, AAFP, University of Wisconsin CEU's. Info: Sarah Z Aslakson CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

DECEMBER 4, 1982: *Wisconsin Chapter, American College of Surgeons,* Hyatt Regency, Milwaukee.

DECEMBER 10, 1982: *Working with the Aggressive Elderly Person,* at Mendota Mental Health Institute, Madison. Contact Training Dept, Mendota Mental Health Institute, 301 Troy Drive, Madison, Wis 53704; phone 608/244-2411.

JANUARY 12-14, 1983: *Clinical Cancer Conference,* The Telemark Lodge, Cable. Sponsored by Marshfield Clinic, Duluth Clinic, Wisconsin Cancer Society and the Minnesota Cancer Society. Info: Office of Medical Education, 1000 North Oak Ave, Marshfield, Wis 54449; ph 715/387-5207.

NEW POLICY

The Editorial Board has established a new policy for the listing of meetings and continuing education programs. Listings of continuing medical education programs, having a registration fee, will be accepted for publication at the following rates: 50¢ per word, with a minimum charge of $20.00 per listing; boxed listing $32.00 per column inch, with free listing in the unboxed columns. Other listings of meetings, without a registration fee, will be accepted without charge at the discretion of the editors. The above policy applies to listings in Wisconsin as well as in other states and countries.

JANUARY 17-19, 1983: *New Therapeutics III: The Results of Recent Advances in Medicine,* at Telemark Lodge, Cable. Sponsored by University of Wisconsin School of Medicine and University of Wisconsin-Extension, Department of Continuing Medical Education. Approved 14 credit hours of Category I of AMA/AAFP; 1.4 CEUs UW-Extension Continuing Education Units. Fee: $235. Info: Ann Bailey, Administrator, CME, 454 WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2854.

JANUARY 21, 1983: *Reality Orientation,* at Mendota Mental Health Institute, Madison. Presented by Institute Staff. Contact Training Dept, Mendota Mental Health Institute, 301 Troy Drive, Madison, Wis 53704; phone 608/244-2411.

JANUARY 27-28, 1983: *Basics of Treatment Planning*, at Mendota Mental Health Institute, Madison. Presented by Institute Staff. Contact Training Dept, Mendota Mental Health Institute, 301 Troy Drive, Madison, Wis 53704; phone 608/244-2411.

FEBRUARY 16-18, 1983: *Medical/Surgical Update '83.* The Telemark Lodge, Cable. Sponsored by Marshfield Clinic. Info: Office of Medical Education, 1000 North Oak Ave, Marshfield, Wis 54449; ph 715/387-5207.

FEBRUARY 19, 1983: Wisconsin Dermatological Society, University Hospitals, Madison.

STATE MEDICAL SOCIETY OF WISCONSIN
Dates and Locations of Annual Meetings
1982-1992

All meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) and the new Hyatt Regency as the headquarters hotel with the exception of 1985, when the meeting will be held at the LaCrosse Convention Center.

1983—Mar 24-26	**1988—Apr 28-30**
1984—Mar 29-31	**1989—Apr 13-15**
1985—Apr 25-27	**1990—Apr 26-28**
1986—Apr 17-19	**1991—Apr 18-20**
1987—Mar 26-28	**1992—Apr 23-25**

Meeting days will be Thursday and Friday; the first session of the House of Delegates will convene on Thursday, the second and third on Friday. Scientific programming will be on Friday and Saturday.

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701. Local telephone: 257-6781; toll-free in Wisconsin: 1-800/362-9080.

MARCH 10-11, 1983: *8th Annual Ophthalmology Current Concepts Seminar '83,* at Concourse Hotel, Madison. Sponsored by University of Wisconsin School of Medicine, Department of Ophthalmology; and University of Wisconsin–Extension, Department of Continuing Medical Education. AMA Category I, University of Wisconsin Continuing Education Units. Info: Sarah Z Aslakson, CME, 465 B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

APRIL 14-16, 1983: *Advances in Infectious Disease*, Madison. Sponsored by University of Wisconsin, School of Medicine, Dept of Medicine; University of Wisconsin-Extension, Continuing Medical Education. Approved AMA Category I, University of Wisconsin-Extension Continuing Education Units, AOA, Family Practice credits. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

OTHERS

DECEMBER 8-10, 1982 (Illinois): *Neurology for the Non-Neurologist,* The Westin Hotel, Chicago. Sponsored by Rush-Presbyterian-St Luke's Medical Center. Approved 20 credit hours of Category I AMA-PRA. Info: University of Office of Continuing Education, Rush-Presbyterian-St Luke's Medical Center, 600 South Paulina, Chicago, IL 60612; ph 312/942-7095. 8-11/82

JANUARY 6-7, 1983 (Hawaii): *Regional Meeting, American College of Physicians,* Hilton Hawaiian Village, Honolulu. Info: Robert A Nordyke, FACP, 2013 Kakela Drive, Honolulu, HI 96822. g10/82

JANUARY 8-9, 1983 (Maryland): *The Role of Clinical Electrophysiologic Studies in the Diagnosis and Treatment of Chronic Cardiac Arrhythmias,* 14th Bethesda Conference, Bethesda, MD. Sponsored by American College of Cardiology. Info: ACC, 9111 Old Georgetown Road, Bethesda, Maryland 20814; ph 301/897-5400. g11/82

JANUARY 17-21, 1983 (Colorado): *14th Annual Cardiovascular Conference*, at Snowmass, Colo. Conducted by the American College of Cardiology and the Santa Barbara Heart and Lung Institute. Approved 20 credit hours Category 1 by ACCME. Info: ACC, 9111 Old Georgetown Road, Bethesda, Maryland 20814; ph 301/897-5400. g11/82

JANUARY 27-28, 1983 (Ontario): *Regional Meeting, American College of Physicians,* Mount Saint Marie, Quebec, ONT. Info: Robert Volpe, MD, FACP, Wellesley Hospital, 160 Wellesley St, E, Toronto, ONT M4Y 1J3. g10/82

FEBRUARY 25-26, 1983 (Kansas): *Regional Meeting, American College of Physicians,* Alameda Plaza Hotel, Kansas City, MO. Info: Max S Allen, MD, FACP, Dept of Medicine, University of Kansas School of Medicine, 39th and Rainbow, Kansas City, KS 66103. g11/82

MARCH 6-9, 1983 (MISSOURI): Sixth National Conference on Rural Primary Care, at Radisson-Muehlebach Hotel, Kansas City. Sponsored by National Rural Primary Care Association and cosponsored by over a dozen national health-related organizations. Hosted by American Academy of Family Physicians. Of interest to anyone involved in rural health care: administrators, physicians, nurses, NPs, PAs, health educators, health planners, students, consultants, etc. Info: Carrie Samuel, Conference Coordinator, NRPCA office, Box 1211, Waterville, ME 04901 (phone: 207/873-7784). g9-12/82;1/83

APRIL 11-14, 1983 (California): 64th Annual Session of American College of Physicians, San Francisco, Calif. Info: American College of Physicians, 4200 Pine St, Philadelphia, Pa 19104. g11/82

AUGUST 4-7, 1983 (Vancouver): *International Doctors in Alcoholics Anonymous Annual Meeting,* Vancouver, British Columbia, at Hyatt Regency Hotel. Info: Information Secretary, IDAA, 1950 Volney Rd, Youngstown, Ohio 44510; ph 216/782-6216. g11/82

AMA

DECEMBER 5-8, 1982: Interim AMA House of Delegates, Miami Beach, Fl.

JUNE 19-23, 1983: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 4-7, 1983: Interim AMA House of Delegates, Los Angeles, CA.

JUNE 17-21, 1984: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 5-7, 1984: Interim AMA House of Delegates, Honolulu, Hawaii. ■

The 1982-1983 Directory of Physicians licensed in Wisconsin, published by the Wisconsin Medical Examining Board, is now available at a cost of $5.00 per copy plus 5% sales tax. Orders to: State of Wisconsin Medical Examining Board, PO Box 8935, Madison, WI 53708. *All orders must be prepaid.*

WISCONSIN SPECIALTY SOCIETY MEETINGS: 1982-1983

Wisconsin Chapter: American College of Surgeons, Dec 4, 1982, Hyatt-Regency, Milwaukee

Wisconsin Chapter: American Academy of Pediatrics, May 19-20, 1983, Pioneer Inn, Oshkosh

Wisconsin Academy of Family Physicians, June 16-18, 1983, Lake Geneva

* * *

SPECIALTY SOCIETY MEETINGS TO BE HELD IN CONJUNCTION WITH SMS ANNUAL MEETING, March 24-26, 1983, Milwaukee

Wisconsin Allergy Society
Wisconsin Orthopaedic Society
Wisconsin Psychiatric Association
Wisconsin Society of Internal Medicine
Wisconsin Society of Pathologists
Wisconsin Society of Physical Medicine and Rehabilitation
Wisconsin Society of Plastic Surgeons
Wisconsin Society for Preventive Medicine
Wisconsin Society of Radiation Oncologists
Wisconsin Surgical Society

News You Can Use

By EARL THAYER, Secretary/BERNIE MARONEY, Assistant Secretary

MUMPS IMMUNIZATION REMINDER. Physicians are reminded that under a new state law, mumps immunization is now required for students admitted to any elementary, middle, junior, or senior high school, and to children admitted to day care centers or nursery schools. Children and students must provide the day care center or school with written evidence of immunization or an immunization schedule. The immunization program for school-age children now includes mumps, measles, rubella, diphtheria, pertussis, polio, and tetanus protection.

MEB ISSUES RULES ON MD DISPENSING. On October 1, 1982 new rules became effective pertaining to the standards physicians must follow in dispensing prescription drugs. For your reference the rule, Chapter Med 17 of the Wisconsin Administrative Code, is reprinted below.

WISCONSIN ADMINISTRATIVE CODE
MEDICAL EXAMINING BOARD
Chapter Med 17
STANDARDS FOR DISPENSING DRUGS

Med 17.01 Authority and purpose. (1) The rules in this chapter are adopted pursuant to authority in ss. 15.08 (5) (b), 227.014 and ch. 448, Stats.

(2) The rules in this chapter are adopted to specify standards practitioners shall follow in dispensing prescription drugs for the protection of the public.

Med 17.02 Definitions. (1) "Controlled substance" has the meaning under s. 161.01 (4), Stats.

(2) "Practitioner" means a person holding a license to practice medicine and surgery or to practice podiatry.

(3) "Prescription drug" has the meaning under s. 450.07 (1) (a), Stats.

Med 17.03 Packaging. A prescription drug dispensed by a practitioner shall be dispensed in a child-resistant container if it is a substance requiring special packaging under s. 16 CFR 1700.14 (1982) of the federal poison prevention packaging act.

Med 17.04 Labeling. (1) A prescription drug dispensed by a practitioner shall contain a legible label affixed to the immediate container disclosing:

(a) The name and address of the facility from which the prescribed drug is dispensed;

(b) The date on which the prescription is dispensed;

(c) The name of the practitioner who prescribed the drug or device;

(d) The full name of the patient;

(e) The generic name and strength of the prescription drug dispensed unless the prescribing practitioner requests omission of the name and strength of the drug dispensed; and,

(f) Directions for use of the prescribed drug and cautionary statements, if any, contained in the prescription or required by law.

(2) NONAPPLICATION OF LABELING REQUIREMENTS. The labeling requirement specified in sub. (1) does not apply to complimentary samples dispensed by a practitioner in original containers or packaging supplied to the practitioner by a pharmaceutical manufacturer or distributor.

Med 17.05 Recordkeeping. (1) PRESCRIPTION DRUGS. (a) A practitioner shall maintain complete and accurate records of each prescription drug received, dispensed or disposed of in any other manner.

(b) All prescription drugs dispensed by a practitioner shall be recorded in the patient record.

(2) CONTROLLED SUBSTANCES. (a) Records required by the federal controlled substances act and ch. 161, Stats., shall be maintained at the location where the drug is received, distributed or dispensed and be available for inspection by authorized persons for at least 5 years from the date of such record.

(b) Controlled substances dispensed by a practitioner shall be recorded as follows:

1. As provided in this section; and

2. On a separate log, in a separate bound log book in which each schedule of controlled substances dispensed is recorded separately and in chronological order with the following information:

a. The name of the substance.

b. Dosage form and strength of the substance.

c. Name and address of the person for whom dispensed.

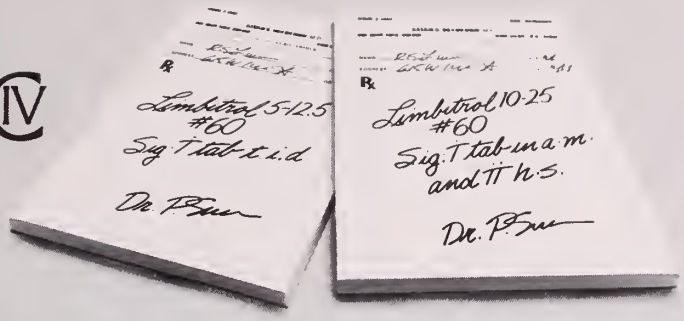
d. Date of dispensing.

e. Quantity dispensed.

f. Name or initials of practitioner who dispensed the substance. ■

Limbitrol® IV

Tablets 5-12.5 each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)
Tablets 10-25 each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt)



In anxious depression,

SPECIFIC FOR THE NONPSYCHOTIC PATIENT

Fits the picture of anxiety/depression correlation

Most patients with a mood disorder have a mixture of anxiety and depression. One clinician[1] found a correlation of 0.7 in anxiety and depression scores; another[2] has estimated that 7 of 10 nonpsychotic depressed patients are also anxious. For the dual symptomatology of anxious depression, Limbitrol provides dual medication.

More appropriate for the nonpsychotic depressed and anxious patient

Limbitrol contains both amitriptyline, specific for symptoms of depression, and a benzodiazepine, specific for the symptoms of anxiety. Thus it is a better choice than other dual agents for anxious depression that contain a phenothiazine, a class of antipsychotic drugs less specific for anxiety and now generally avoided in nonpsychotic patients.[2,3]

Avoids the risk of tardive dyskinesia carried by the phenothiazine combinations

The causal relationship between the phenothiazines and other extrapyramidal side effects, including tardive dyskinesia, is well established. In contrast, the reported incidence of these adverse reactions with Limbitrol or either of its components is rare.

References: 1. Clagham J: *Psychosomatics 11*:438-441, Sept-Oct 1970. **2.** Rickels K: Drug treatment of anxiety, in *Psychopharmacology in the Practice of Medicine*, edited by Jarvik ME. New York, Appleton-Century-Crafts, 1977, p 316 **3.** Baldessarini RJ, Tarsy D: Tardive dyskinesia, in *Psychopharmacology: A Generation of Progress*, edited by Lipton MA, DiMascio A, Killam KF. New York, Raven Press, 1978, p 999

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Relief of moderate to severe depression associated with moderate to severe anxiety.
Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use; then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.
Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

Usage in Pregnancy: **Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).
Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated. sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.
Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.
The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs.
Cardiovascular. Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.
Psychiatric. Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.
Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.
Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.
Allergic. Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.
Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.
Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.
Endocrine. Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels.
Other. Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.
Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.
Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly. Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased to six tablets or decreased to two tablets daily as required. Limbitrol 5-12.5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses.
How Supplied: White, film-coated tablets, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500; Tel-E-Dose® packages of 100, Prescription Paks of 50.

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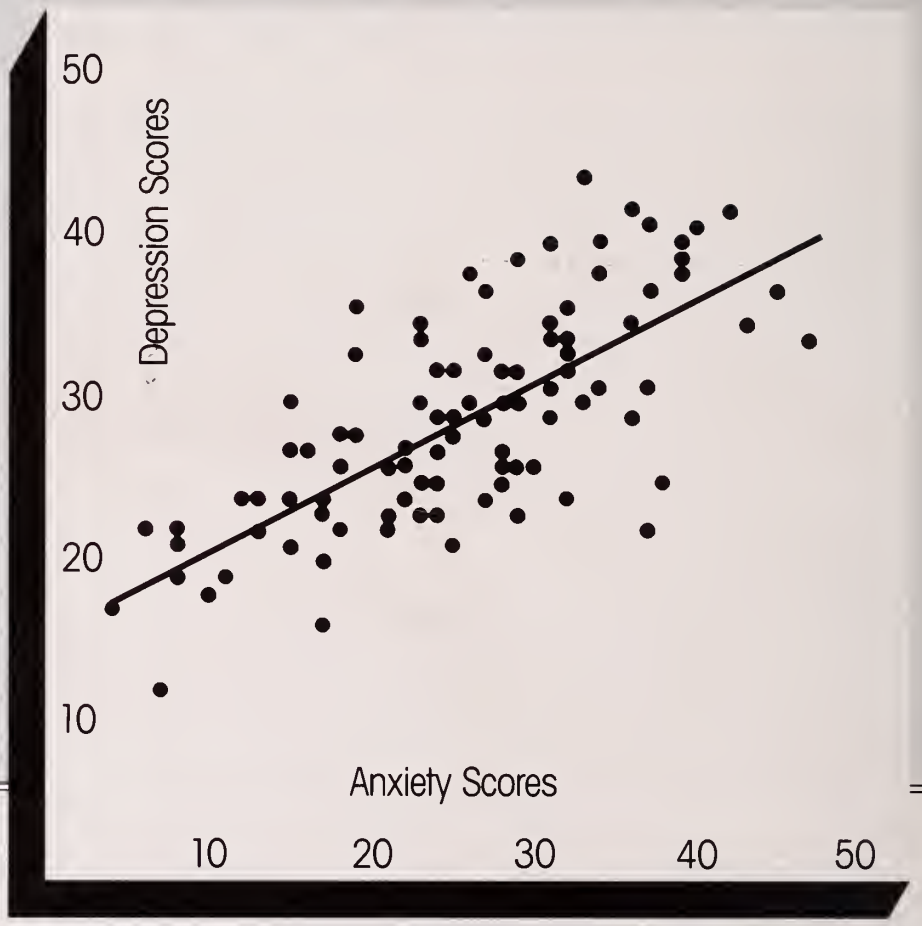
MORE DEPRESSION MEANS MORE ANXIETY...



The graph illustrates the close correlation between depression and anxiety derived through the MMPI and the Taylor Manifest Anxiety Scale in 100 nonpsychotic psychiatric patients. The Coefficient of Correlation is 0.7. As depression increased, so did the anxiety levels.
—Adapted from Claghorn J[1]

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ROCHE®

1. Claghorn J: *Psychosomatics 11*:438-441, Sept-Oct 1970

Please see summary of product information on inside cover.

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STACKS

WISCONSIN MEDICAL JOURNAL

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WISCONSIN MEDICAL JOURNAL (ISSN 0043-6542) is the official publication of the State Medical Society of Wisconsin, devoted to the interests of the medical profession and health care in Wisconsin. Its affairs are handled by the Editorial Board, subject to policy direction of the Society's Board of Directors. The Managing Editor is responsible for the production, business operation, and coordination of contents as well as the final responsibility of the entire publication. The Editorial Director is responsible for Editorials. In Editorials, official positions of the Society will be expressly identified as such; all others are views of the writer and not necessarily those of the Society. Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed in the pages of the Journal. Indexed in "Index Medicus," "Hospital Literature Index," and "Cambridge Scientific Abstracts." Contents page included in "Current Contents/Clinical Practice."

Publication Information

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President's Page

.....Gerald C Kempthorne, MD

We must adapt to "forces of change"

DON'T SURRENDER leadership to frustration, fears, or foes. The medical profession has long held a dominant position in healthcare delivery. That dominance is slowly receding as the "forces of change" manifest their impact on the practice of medicine. Physicians have assumed that their superior role in patient care would rest on quality and the important doctor-patient relationship. However, it is clear that the scene is changing due to forces potentially beyond our control. Clearly, we must adapt to change or lose our crucial input to the evolutionary process. We must not be oblivious to the mood of the country. Any amateur historian will surely remember the fate of France and Russia, when the leadership chose to ignore the wishes of the people.

We are blessed with two very important allies in the healthcare field as we face the inevitable "revolution." The three great forces of the hospital structure are administrators, physicians, and nurses. Hospitals certainly need doctors and nurses, just as importantly as physicians need a base in which to practice their profession. If we are to see a great change in the healthcare field, then it is absolutely essential that this trio of mighty important people remains united in effort and dedicated to improvement in relationships. The changes to come will be substantially affected by this influential "community of colleagues" if we can continue to pursue sustaining and meaningful cooperation. Medical history is full of marvelous stories of the wonderful relationships between physicians and nurses. Until recent years hospital administration and physicians enjoyed a good working relationship. However, with the influx of so many changes including new technology, manpower problems, wages, unions, insurances, turf questions and others, hospital administrators and physicians in some settings have drifted apart. If a bulwark of cooperation is restored to the traditional trio, then it will be very difficult for the "management system" to plot and plan the future of healthcare direction without the voice of all three. If physicians are to survive the "siege," they will have to modify their dominant image by demonstrating their intense interest by working with hospital personnel and their nursing colleagues in a cooperative and equal fashion.

There is no question concerning the input from government as the changes of healthcare delivery evolve. We cannot be responsible for the whole spectrum of healthcare delivery, nor should we be so presumptuous as to assume such a role anymore in light of the changes. However, to preclude our input would be very bad and unfortunate. Organized medicine is a dynamic force with great influence when used correctly. In order to manifest that tremendous help to the "planners," it will be necessary for us to alter our traditional course. The days are over when we can simply *ask* our legislators to do something for us. We must earn our right to ask for anything by demonstrating a new relationship. Clearly, you cannot expect a representative to respond to our call just because we are physicians with a cause—even if we are right. We must begin from this day forward to get to know our legislators in a personal and sincere way. In order to begin this new relationship, it will be important to call on the legislator when we don't necessarily have an "axe to grind" and assure him or her we are ready, willing, and able to assist on matters relating to healthcare. Let us not be reluctant to invite the legislators as well as the new physicians in our areas into our homes in order to get to know these very important people—better! We can expect far more from our representatives if we abandon the aloofness some of us have shown over the years. This goes for candidate interviews, too. We didn't develop the Physicians Alliance to replace physicians in the political process, but rather to assist us. The destiny of our medical future may very well rest on the restoration of the physician-legislator working relationships. The medical profession in the form of the State Medical Society of Wisconsin has been offered to the State of Wisconsin as a serious and dedicated body of physicians willing to serve and advise when called upon by the new Governor and the Legislature.

We need not surrender our leadership in healthcare planning because of frustration, fears, or foes. It will require a new concept of change on our part. Essentially, it means we must preserve our traditional relationships with nurses and hospitals in a colleague-to-colleague atmosphere. We clearly must crawl out of our sanctuary of complacency and develop a relationship with government on the highest, positive tone. To be adversarial today is to close the door to the important advice and counsel we are so blessed to be able to provide. ■

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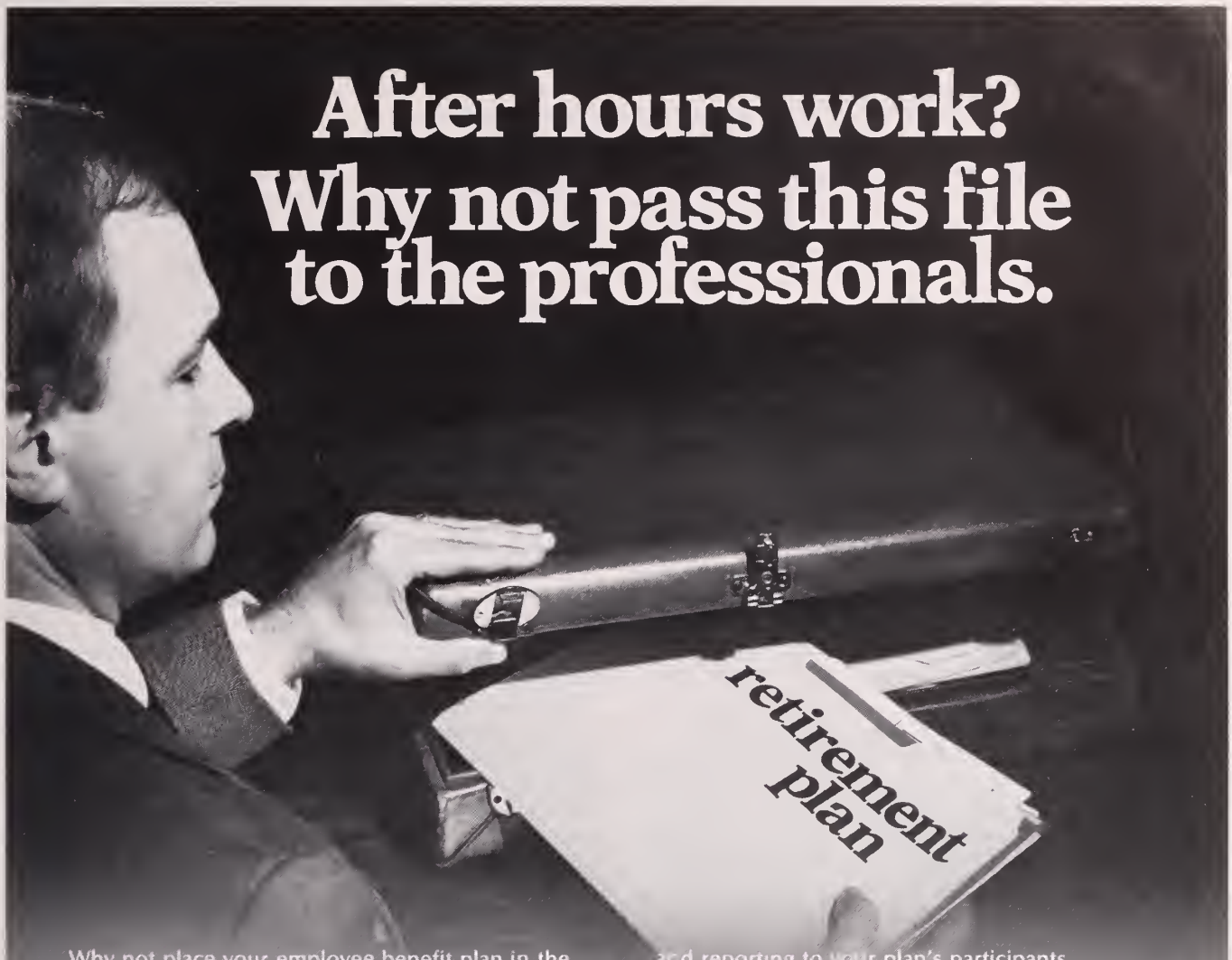

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Editorials WAYNE J BOULANGER, MD, *Editorial Director*

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TV as an educational tool for physicians

ELSEWHERE IN THIS issue, a group of Wisconsin physicians presents material on educational TV *(Health education via cable TV as a public service and subscriber survey),* describing the mechanics of producing the series, giving the results of a subsequent subscriber survey about preferences for health education topics, and commenting on some aspects of physicians' participation. As one who has had some experience in TV presentations and more experience in courtrooms wherein somewhat similar skills are required to achieve optimum presentation benefits, I call physicians' attention to the article and to the potential of TV as an educational tool.

In my judgment, physicians can and should investigate TV to help instruct their patients, their patients' relatives, and others. There seems to be no question that if physicians do *not* utilize TV, others *will,* on medical topics, possibly with results deleterious to the good of patients and medical practice.

One very important point comes to mind on reading the article and thinking about the subject: Like virtually every other discipline or system, TV requires practice and planning to achieve smooth, worthwhile, acceptable results. When physicians use TV as a tool (and I think many of them should), they must plan, work, and train themselves in its arts, requirements, and limitations. "Inspiration is no substitute for perspiration."

—Chesley P Erwin, MD

Lawyers suggest a cure

EACH YEAR THE GOVERNORS OF THE American College of Surgeons are asked to enumerate the major concerns of their colleagues when they submit their annual reports to the Chairman of the Board. Each year for the past several years the professional liability problem has headed the list of concerns.

Because of the great interest expressed by the governors, the College arranged a special program on the topic: *Malpractice—Professional Liability—The Present and the Future from Two Perspectives.*

There were two speakers—both attorneys—one who makes a living bringing suits against doctors and one who makes just as good a living defending them. Both were recognized experts in the arena of medical malpractice. Not surprisingly, they were in complete agreement with each other with regard to the magnitude of the problem, the probability of more and larger awards in the future, the futility of physician efforts to alter the course of the blitzkrieg through legislation aimed at statutes of limitation, setting ceilings on awards, and/or attacking attorneys' contingency fees.

They made a lot of sense.

Even in Wisconsin where our liability insurance premiums are miniscule compared to those of New York and Florida, awards are threatening to break the bank; and our Legislature and our adoring public are not disposed to bail us out. So what shall we do?

The attorneys had a simple answer, and it's really the only one that has a chance to work: Don't do (or fail to do) things that will injure the patient, and you won't be sued. Putting it another way: If you want to keep your premiums down, weed out the incompetent physicians on your hospital staff and keep your own skills sharp. When in doubt, holler for help! Everyone knows there will still be an unavoidable bad result occasionally, and the courts will make a multimillion dollar award now and then; but in the end we'll come out ahead, and so will our patients. —WJB

"Unincorporating"

THE TAX EQUITY and Fiscal Responsibility Act of 1982 was passed on September 3. This new tax law has changed the tax situation in ways that may apply to many physicians. The major changes are in the ways physicians plan for retirement and also in the way they structure their practices.

The new rules will limit incorporated doctors' retirement plan contributions and there are additional restrictions within a new classification called "top heavy plans." Physicians who have defined benefit retirement plans with benefits already funded to exceed the new law's limitations will be frozen out from making additional retirement plan contributions until 1986 or perhaps even later. Also affected are some physicians who purchase life insurance through the retirement plans.

Although the changes to incorporated physicians' retirement plans are uniformly more restrictive, the contrary is true for unincorporated physicians' Keogh plans. The Keogh plan rules have been liberalized to make those plans comparable with corporate plans. Under the new law physicians will

now be able to self-trustee their own Keogh plans, make quite substantial nondeductible voluntary contributions, and integrate the retirement plans with Social Security.

Physicians considering incorporation in the near future may wish to reconsider their plans. Corporate practice will be beneficial in only very few instances, such as where a high level of medical expenses is incurred regularly.

There is also a change in the retirement plan distributions. Beginning in 1983 the exclusion from estate tax has been limited to $100,000. This will necessitate physicians reviewing their present estate plan as the $100,000 cap on the estate tax exclusion will result in substantially increased estates.

In passing the law Congress recognized that many presently incorporated professionals may wish to "unincorporate." The additional expenses incurred by practicing through a corporation will often equal or exceed the dollar benefits from the few remaining corporate fringe benefits. Congress inserted special rules to apply only in 1983 and 1984 for liquidating professional corporations. Those rules limit the negative tax impact which would normally accompany the dissolution of a corporation.

There are also changes in the tax credit rules for equipment placed in service after 1982. Speeding up the decision to buy might save tax deductions equal to one-half of the tax credit.

All of the above information was contained in a lengthy article submitted to the *Wisconsin Medical Journal.* It was prepared by Geoffrey T Anders, Leif C Beck, J Thomas Martin, Michael J Gannon, all attorneys with The Health Care Group of Bala Cynwyd, PA. The authors recommend that physicians should be generally aware of the new tax law provisions and begin planning to reorient their practices and finances with a view to the now changed tax law environment. Although the entire article will not be published, it is available to physicians upon request. —VSF■

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Special

The role of the physician assistant

Susan Rammer Milliken, PA-C, Waukesha, Wisconsin

In May 1981 the *Wisconsin Medical Journal* published an article entitled "The Clinical Preceptorship—The Capstone of UW-Madison Physician Assistant Education," by Patrick Runde, PhD. This article has prompted the medical community to request more information about the role graduate physician assistants are fulfilling in the delivery of healthcare and the particular settings in which they are employed.

The physician assistant (also referred to as a PA) is a professional member of the healthcare team, qualified by both academic and clinical training to perform a minimum of 70% of the clinical procedures performed by a general practice physician.[1] The function of a PA is to assist with patient care, freeing the supervising physician to focus on more urgent or complex patient problems.

It is important to note that a physician assistant is a *dependent* practitioner who functions under the supervision of a licensed physician and augments this physician's data gathering and technical abilities. In this role the PA acts as a member of the healthcare team to extend the medical services provided by the supervising physician.

The supervising physician may delegate to the PA those medical procedures and other tasks that are performed within the normal scope of the practice according the the Wisconsin Administrative Code, Chapter Med. 8.05.[2] Therefore, the utilization of physician assistants is subject to the limitations set forth by state laws, rules, and regulations. Also, PAs may not redelegate a task delegated to them by the supervising physician.[3]

The PA may perform "patient services" as defined by the Wisconsin Administrative Code, "the initial approach to a patient of any age in any setting to elicit a personal medical history, perform an appropriate physical examination, and record and present pertinent data in a manner meaningful to the physician." Depending on the case and the work relationship, the PA may consult with the supervising physician to review the preliminary diagnosis and treatment plan. In 13 states (including Michigan and New York) physician assistants have prescriptive privileges, although in Wisconsin any prescription must be generated by the supervising physician.

After applying for and receiving staff privileges, the PA may function in the institutional or hospital setting by "assisting at surgery, making patient rounds, recording patient progress notes, compiling and recording detailed narrative case summaries,

EDITORIAL COMMENT. *My position relative to the physician assistant is highly biased, most likely because I have had the opportunity to work with the cream of the crop. As a cardiac surgeon, while I cannot prove they have made me more productive, this is quite likely. What is certainly true is that they have made my professional life much more pleasant. They develop skills that make them an integral and important part of the surgical team, both in the operating suite and during the postoperative period.*

The physician assistants with whom I have had the pleasure of working are true professionals in every sense of the word. They develop patient rapport, the patients trust them, they maintain physician and patient confidentiality, and most important have a true concern about the patient's outcome.

To avoid misunderstanding these physician assistants perform under my supervision which they most willingly accept. I personally cannot conceive of continuing my present surgical practice without the support of a physician assistant.

Richard D. Sautter, MD
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Marshfield Clinic
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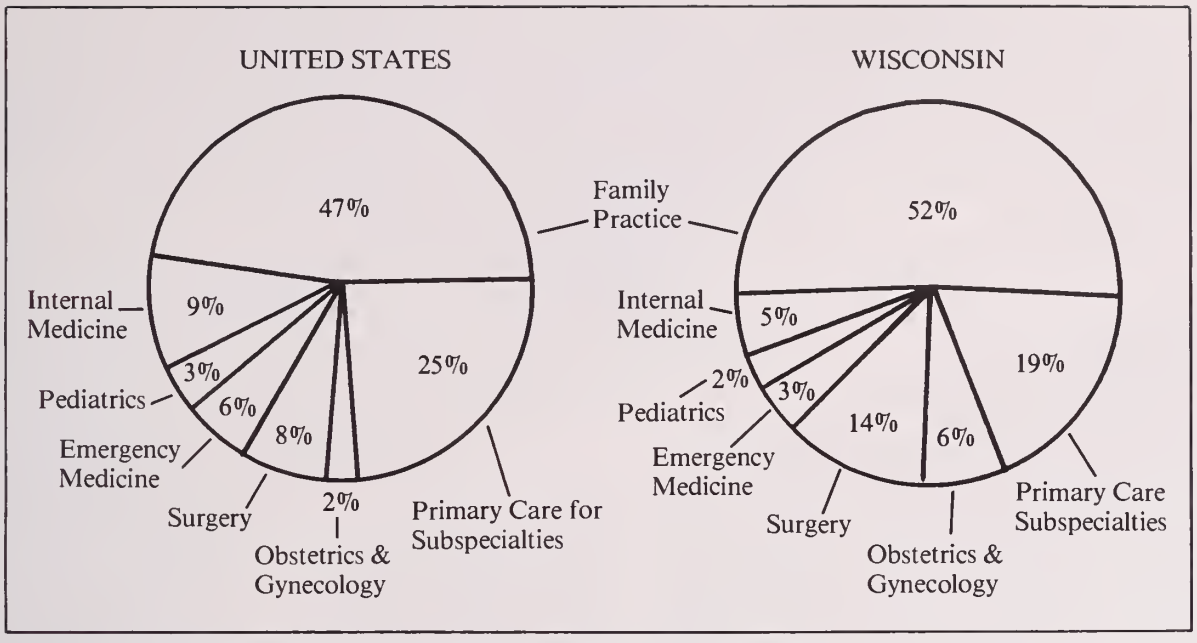

FIGURE 1—*Statistical breakdown of physician assistant utilization in the medical specialties nationally and statewide.*

and accurately writing or executing standing orders or other specific orders following consultation with and at the direction of the supervising physician," according to the Wisconsin Administrative Code. The implementation of hospital orders and countersignature of records are regulated by the administration of the individual hospital.

Educated and trained in a wide range of technical procedures, the PA is able to perform musculoskeletal, pulmonary, ENT, cardiovascular, gastrointestinal, genitourinary, obstetrical and gynecological examinations, as well as therapies. The following are examples of tasks conducted by Wisconsin physician assistants who responded to a recent survey:[4]

Take a history	100%
Perform a physical examination	96%
Start intravenous fluids	60%
Apply casts	62%
Treat sprains/strains	81%
Introduce nasogastric tube	42%
Introduce endotracheal tube	20%
Obtain specimen/perform lab tests	65%
Take/interpret electrocardiograms	54%
Perform cardiopulmonary resuscitation	75%
Immunizations	65%
First-assist surgery	59%
Suture wounds	86%
Patient education	96%
Write routine hospital orders	66%
Assist management of hospital patients	71%
Diagnose and treat commonly occurring diseases	89%
Community service projects	51%

PAs also are actively involved in counseling and patient education including, but not limited to, preventive medicine, diet, disease processes, treatment, and normal growth and development.

Physician assistants function in many settings and work with a variety of specialties under the direction of a supervising physician. These settings include:[5]

> Private practice (solo or multispecialty) and comprehensive health clinics, hospitals, approved satellite clinics, federal and state prison systems, uniformed and nonuniformed services, nursing homes, health maintenance organizations, industrial clinics, student health services, urban community centers, and physician assistant programs.

Figure 1 shows the statistical breakdown of PA utilization in the medical specialties nationally and statewide.[6,7]

A physician's utilization of a physician assistant creates a unique healthcare team. A PA is a dependent practitioner functioning in a variety of settings to provide expanded medical care in conjunction with the supervising physician. The majority of PAs are employed in Family Practice, performing various patient services and technical procedures. Any further questions may be answered by contacting the Wisconsin Academy of Physician's Assistants administrative office at the State Medical Society Headquarters in Madison.

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Special

Health education via cable TV as a public service and subscriber survey . . .

Roland D Paegle, MD; Tom Anderson, MD; Harold L Brooks, MD; Steven R Gambert, MD; Peter Sigmann, MD, Milwaukee, Wisconsin

EDITORIAL COMMENT: *This article describes the evolution, including the mechanics of developing and producing a health education series via cable TV for a local community, and the results of a subsequent cable-TV subscriber survey about preferences for health education topics. This information may be helpful to physicians in other communities who are considering various means to reach the lay public.* —RDP

PHYSICIANS, CLINICS, and hospitals are facing an ever-increasing demand by patients and the public for more effective healthcare education. The interest in specific topics varies considerably[1,2] The public is also becoming more aware of the value of health maintenance and preventive medicine. If the quest for information is not satisfied by physicians and other health professionals, the public will have to rely on the advice of less qualified persons, ranging from well-intentioned dilettantes to purveyors of old-time panaceas or new-fangled curealls. Health education should also help patients and their families distinguish between information disseminated by responsible media, including scientific journals, and that from less than reliable sources.

Why TV? The demand for more information comes at a time when physicians are struggling to keep up with the medical information explosion. Increased use of mass media, especially video and broadcast television, appears to be the realistic solution for satisfying this demand without eroding the medical professional's time. The growth of local cable-TV companies can enable medical professionals to target health education topics to specific audiences regardless of size. Furthermore, the advent of low-cost, portable, video recording or duplicating equipment provides the option for excerpting and/or reediting programs for teaching of students or patients in groups or individually.

National polls conducted by the Roper Organization from 1959 to 1979 revealed that more adults, even with college training, prefer television to radio and printed media as a means of obtaining news and information. As a result of their reorientation towards TV, "many Americans have been more exposed to audiovisual communication than to the written media."[3] Therefore, it is no surprise that information may be disseminated better and comprehended more completely if it is infused via an audiovisual route.[4] Physicians are turning to TV in growing numbers. The American Medical Association already has held two national meetings on this subject,[5] and is planning a third.

Maintenance of "personal good health" motivated the AMA to publish a family medical guide.[6,7] A State Medical Society of Wisconsin brochure for the public[8] states that "a healthy lifestyle can have a major impact on your medical bills. Only ten percent of your good health is dependent upon the medical care system, while 90% depends on you and your lifestyle." Such promotion of lifestyles can be enhanced via TV.

Health Education Committee. A physician-directed Health Education Committee was established to evaluate the options for providing health education to patients and the public. Representatives from five institutions participated (Fig 1). Taking into account the limited availability of "talent" and over-the-air broadcast time, it was decided to try cable TV.

TV skills training. The most efficient way to assure accurate health education is to have medical professionals conduct the presentations. However, many physicians have never had training in educational or media methodology. Even medical school

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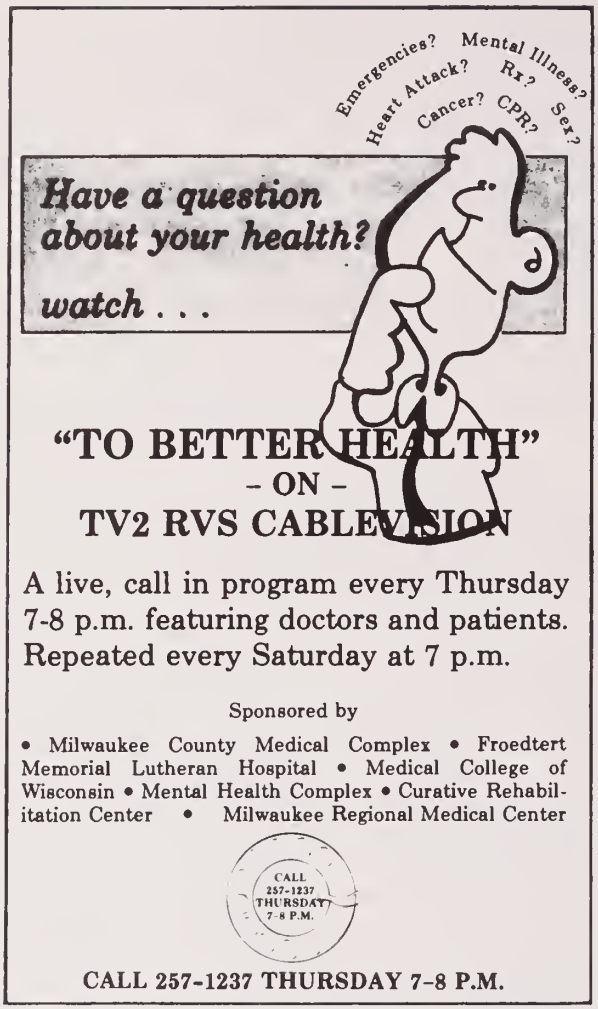

FIGURE 1—*The front of the promotional two-page insert about the health education series contains only essential but practical information about the programs.*

faculty may lack skills in audiovisual modes of communications.[3] Therefore, a series of five workshops was developed in order to teach TV skills to the medical professionals of our institutions. The series, entitled "Medical and Health Education Videoproduction Workshops," was designed by a physician, who has subspecialized in medical TV, and taught with the help of guest faculty as well as personnel from the medical school. Broadcast TV facilities in town helped provide hands-on-training. Specifics about the workshop series are available from the authors upon request.

Format of TV programs. When planning the program format, it is important to keep the target audience and its motivations in mind. *Health information* type programs are aimed mainly at the well population. Hence the programs have to compete for attention with every other show. The health information shows often are fitted into newscasts or use its short-style items, often delivered at a quick pace. The viewer just scans the items, looking for ones that might be useful some day or which might help with common problems, such as colds, beauty tips, exercise, and the like. On the other hand, *health education* programs are aimed mainly at patients, their families, and perhaps some of their neighbors, a much narrower segment of the general population. However, the motivation to view is much higher because of personal involvement. When one considers the prevalence of heart disease, cancer, arthritis, geriatric ailments, or stroke, the potential size of such "narrowcast" audiences can be substantial. In addition, certain groups require more medical attention than others, for example cancer patients and the elderly. Specifically, the elderly comprise 11%-12% of the total population but they utilize approximately 30% of health costs.[9] In addition, the mobility of the elderly often is impaired. Obtaining advice by just calling can reduce transportation costs and waiting time. Additionally, such advice could also make them more efficient users of medical care.

Because of the above considerations we adopted the live, hour-long, call-in format (Fig 1). An "800" number was provided for long-distance calls. First and third weeks' programs were devoted to cancer, the rest to cardiology, geriatric, emergency, and general internal medical topics. The physicians-broadcast producers were encouraged to invite patients to participate as panelists on TV because patients can offer much practical advice. In addition, the presence of patients on the program reminds the physicians to use laymen's language during their presentations.

Program promotion. A new program has to be promoted adequately. The current recession affects most hospitals severely. Hence the public relations help, which our institutions could provide, was small. Initially we had to rely mainly on word-of-mouth and several large ads (paid for by the TV company) in the TV section of the largest metropolitan newspaper. Four months after the initiation of the programs a sampling of 10 cablevision subscribers in a one-block area disclosed that only two had seen or heard of our health education programs. Therefore, additional effort was necessary. It included the mailing of an insert with the monthly bill to each of the 30,000 subscribers to the RVS Cablevision service to insure that each one was notified of the availability of the health education programs.

Survey of subscribers. The survey was attached to the promotional information and consisted of a three-item questionnaire printed on one part of a folded card. The other part contained the program schedule for the next four months together with brief information about the broadcasts (Fig 1). The respondents had to use their own stamp for return mail. The 412 replies received during the next four weeks were tabulated.

Question 1: "Dear viewer, to help in planning for future programs, we would like to know what medical and health subjects you want to know more about. Please check the appropriate boxes below."

The answers are listed in Table 1. Write-in comments were also received. Most were favorable. Some unexpected ones and/or practical suggestions were also received, including:

"I read so many articles I don't know what is the truth." "Can it be repeated on WYMS or UWM radio?" "New mothers need somewhere to call their questions besides their own busy doctor! Is it feasible to run different topics during the week? For instance, childcare first Thursday of every month, diet and nutrition second Thursday, and so on, and repeat monthly and have it ongoing?"

Questions 2 and 3 dealt with broadcast timing. 323 (78.4%) respondents considered the current schedule as convenient, while the remainder suggested alternatives or expressed no preferences.

Table 1—*Topic preferences of cable-TV subscribers*

Topic Preference (arranged in order of decreasing percentage of responses*)	Number of Individual Respondents	Percentage of Responses
Nutrition and diet	240	58.2
Medical emergencies	186	45.1
Aging	142	34.5
Heart disease	139	33.7
Sex	132	32.0
Skin care	132	32.0
Eye care	119	28.8
Cancer	116	28.1
Mental illness	113	27.4
Medical costs	101	24.5
Community medical services	93	22.5
Pregnancy and child care	91	22.1
Sports injuries	82	19.9
Orthopedics	77	18.7
Plastic surgery	69	16.7
Rehabilitation	40	9.7
Other	114	27.6

*Responses include 257 individual items on specific diseases, organ systems, and procedures. Most are mentioned by only a single individual. Only the ones mentioned by 10 or more of the respondents are listed and include: arthritis—20; preventive medicine, lifestyle, and exercise—18; diabetes—16; healthcare system and financing—16; family planning and infertility—12; alcohol and drugs—12.

Reluctance to ask questions. To obtain insight into viewer responses to the programs, one of the authors (RDP) viewed the programs together with two neighbors at a time during five successive weeks. This approximated the small group environment in which most TV viewing takes place. The most striking findings were: (1) the empathy felt toward the patients on the programs, and (2) the difficulty the viewers had convincing themselves to call-in a question. The reasons for the latter can be summarized by the answers: "I don't know enough about the subject to ask a question" or "I don't want to ask a silly question." The hesitancy was especially striking since the families of the neighbors had had to cope with cancer, heart attacks, and geriatric ailments, topics discussed during the respective TV programs.

The first reason presents a major problem, which perhaps can be overcome gradually, as the TV programs continue to build a foundation of knowledge for the viewers. A recent study[10] demonstrated that even cancer patients and their families often fail to ask questions until someone gives them some background material via an educational videotape. Such videotaped programs also decrease the anxiety felt by patients and their families. We are aiming for similar results with our TV broadcasts.

The second reason was quite puzzling at the beginning because in private the neighbors had a large number of questions which they directed at each other and the observer. Placing a call, however, was another matter! This hesitancy may stem from the widespread fear of public speaking. According to a survey of laymen, "the anxiety of standing before an audience beat out fear of death."[11] To minimize this fear, the callers are not asked to give their names. Our TV panelists also encourage the viewers by stating during the broadcasts that no question is silly if it pertains to a real health problem.

Physician attitudes and participation. A major factor in success of a local medical TV program involves recruitment of the best personnel and faculty. In our experience, that is not always an easy task. Sometimes the most knowledgeable experts in a field may not be willing to take the time necessary to prepare and execute an excellent program, may not be emotionally committed to the concept of patient education through media broadcasts, or may not be able to communicate or perform well in front of a live television camera. We also encountered a degree of skepticism about the value of engaging in media broadcasts. A corollary response is to assign a lower priority for such media activities than is necessary to develop a high-quality program. Dealing with this attitude requires skill and practice by the program directors. However, most individuals quickly realize the value of medical programming once they have experienced success, especially if the broadcast involves live-audience participation with lively interchange during a call-in show.

Conclusions. It is clear from our survey that there is considerable interest in health education in our portion of Wisconsin. The utilization of such public-service programs can be expected to grow as the

community becomes aware of its availability and becomes accustomed to using the call-in feature. The programs also extend a physician's educational reach considerably. How effective this reach can be remains to be determined by further studies. During the personnel training and broadcast implementation, it became obvious that the number of educational research studies about TV as a teaching tool was rather scanty. This void should be filled.

Since programs, such as the one described above, are likely to be presented as a public service rather than as a commercial venture, it is unlikely that the producers will have substantial budgets to spend on elaborate stage sets, off-site videoproductions, or visual aids for clarifying complex medical topics. Hence, cooperative arrangements and exchange of materials between medical professional associations and institutions could be very beneficial for enhancing local broadcasts.

EDITORIAL COMMENT. *In reviewing this article, we were happy to see that the medical community is becoming more interested in health education and preventative medicine. We agree completely with the main premise of the article, that there is a great void of information in the public sector regarding health. We agreed with the authors that television offers an ideal medium for passing on healthcare to large audiences. They have shown that the more senses that can be stimulated the greater the chances for learning, and certainly television relates the visual and auditory senses. Because of the public's want for health information and television's availability as a teaching tool, the cable health network has been formed. This organization transmits high quality health related programs to many cable companies via satellite.*

We did disagree with the author's thought that medical and health education video production workshops will convert physicians into Johnny Carsons and Dan Rathers, and that television could be produced without invading the medical professional's time. We feel that is absurd in that the American public is a very sophisticated media consumer and whenever a program is produced and aired, either commercially or via cable TV, it must compete with all the sophistication and razzle dazzle of Hollywood, etc, to be watchable. It takes lots of time to produce a quality education program. It takes qualified video professionals to be able to compete in the media marketplace for viewers. The idea that you can take off an hour or two early one afternoon and work out a quality TV program is just not accurate.

Also, the idea of television call-in show demonstrates that the medical professionals have little knowledge about television programming, a call-in program does not utilize the primary asset of television, that of being a vision. It is impossible to predict the caller's question and therefore impossible to prepare visual information with which to answer the question; you then end up with a radio call-in program instead of television.

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Human tumor stem cell clonogenic assay sensitivity in malignant tumors and clinical correlation

Tarit K Banerjee, MD; James J Marx Jr, PhD; Susan K Spencer, MT (ASCP), and **Ellie Tiffany**

Marshfield, Wisconsin

ABSTRACT. *The human tumor stem cell assay (HTSCA) has been used to evaluate the clonogenic response of 200 tumors of various types. The clonogenicity by a panel of routinely used chemotherapeutic drugs was tested and the results retrospectively compared to the tumor response when the patients received the drug regimen. The results demonstate that an average of 58% of the tumors tested could be grown* **in vitro** *and the drug responses predicted. The HTSCA was effective 88% of the time in predicting which drugs a tumor would be resistant to and 68% of the time to which drugs a tumor would be sensitive. The HTSCA provides an advantage to the clinician which can be used by the clinician in selecting a form of chemotherapy for a patient.*

TUMOR STEM CELLS are both the cell renewal source of a tumor and the seeds of metastatic spread for that tumor. Malignant tumor cells from animal sources have been grown in culture for many years and are widely available to investigators for study.[1] Human tumor cells have been much more difficult to culture successfully. The ability to grow human tumor cells under conditions where normal cells were inhibited was achieved by Hamburger and Salmon[2] using a soft agar technique. Using this technique they were able to predict the relative sensitivity of the tumor to a variety of chemotherapeutic agents.[3] Although many attempts have been made to identify methods for predicting tumor drug response,[4] the clonogenic capability of tumor cells appears to be the best differential of reactivity. Since that original description, a number of other laboratories, including our own, have been interested in applying this technique to a variety of tumor types tested with the usual battery of chemotherapeutic agents available to the clinician. At least two laboratories are providing this assay on a purely commercial basis.[5,6]

Our laboratories have been actively culturing malignant tumors for the purpose of predicting the response of the tumor to chemotherapeutic agents. This report presents the results of culturing 200 tumors from different tissue sources and retrospectively comparing the *in vitro* test results with the response of the tumor following treatment.

MATERIALS AND METHODS. Two hundred tissue or fluid specimens from 156 patients were obtained for the human tumor stem cell clonogenic assay (HTSCA) over a one-year period. The age range of the patients was from 16 years to 94 years. The median age was 66 years. The patients included in this study were not preselected prior to performing the HTSCA.

Aseptic technique was used in collecting the specimens and transported to the laboratory expeditiously. Surgical specimens were transported in 20 ml of cold McCoy's 5A (Grand Island Biologicals, New York) supplemented with 10% fetal calf serum (FCS), (Sterile Systems, Inc, Logan, Utah), and 200 mM glutamine, and 5000 U/ml penicillin/streptomycin. Fluid specimens were collected in phenol-free heparinized vacuum bottles (10 U/ml). Samples were processed as soon as possible after reaching the laboratory.

Cells from fluid samples were collected by centrifugation at $150 \times g$ for 15 min and washed twice with Hank's balanced salt solution (HBSS) containing 10% FCS. Cells from solid tissue samples were collected by a combination of mechanical disruption and enzyme digestion. Tissue was cut into 0.5 mm sections using a Stadie-Riggs microtome. The sections were incubated in an enzyme cocktail consisting of 0.04% collagenase and 0.002% DNase in RPMI 1640 medium supplemented with 10% FCS for 3 to 24 hr. The digested tissue solution was poured through a 100-mesh tissue sieve. The sieve was washed with McCoy's 5A and the cells were centrifuged at $150 \times g$ for 10 min and the supernatant removed. The cell pellet was washed and resuspended in CMRL 1066 supplemented with 10% FCS, 5% horse serum, 200 U insulin, 30 mM ascorbic acid, 200 mM glutamine, 5000 U penicillin/streptomycin, 0.3% agar, 6.6 mg/ml asparagine and 50 mg/ml DEAE-dextran to a final cell concentration of 5×10^5 cells/ml.

Clonogenicity was determined by plating the cell suspension on 1.0 ml of an enriched McCoy's 5A containing the appropriate dose of the test drug or

From the Marshfield Clinic and the Marshfield Medical Foundation Inc, Marshfield. This work is supported by the Marshfield Medical Foundation and the Marshfield Clinic. Reprint requests to: Tarit K Banerjee, MD, Marshfield Medical Foundation, 510 North St Joseph Ave, Marshfield, Wis 54449 (phone: 715/387-5416). Copyright 1982 by the State Medical Society of Wisconsin.

media control in 0.5% agar. The culture dishes were 35 mm plastic 6-well trays (Linbro Scientific, New Haven, CT). Each drug was tested in triplicate at the appropriate drug concentration corresponding to the peak serum level following a specified drug dose (1 x) and 0.1 x. The cultures were incubated at 37 °C in a CO_2 humidified atmosphere for up to three weeks. The cultures were examined at 1, 7, 14, and 21 days by inverted phase microscopy. Colonies were considered aggregates of ten or more cells, and were scored as colonies (clones) per plate. All cultures were compared to the 24-hr culture to control for nonclonal aggregates. Growth was defined as more than 30 colonies/plate and inhibition of colony formation occurred when more than 50% of the colonies were inhibited (>70% = sensitive; >50% = intermediate). The average of the three plates was calculated.

The drugs which were tested depended somewhat on the number of cells obtained from the sample. When sufficient cells were obtained, the following drugs were tested: doxorubicin HCl [Adriamycin] (0.5 μg/ml); actinomycin-D (0.075 mcg/ml); melphalan [Alkeran] (0.3 mcg/ml); cytarabine [Ara-C] (250 mcg/ml); bleomycin [Blenoxane] (4.0 mcg/ml); carmustine [BCNU] (2.0 mcg/ml); cis-platinum (2.5 mcg/ml); cyclophosphamide [Cytoxan] (35 mcg/ml); diethylstilbestrol [DES] (1.0 mcg/ml); dacarbazine [DTIC] (10 mcg/ml); ethynylestradiol [Estinyl] (1.0 mcg/ml); fluorouracil [5-FU] (60 mcg/ml); fluoxymesterone [Halotestin] (1 mcg/ml); megestrol [Megace] (1 mcg/ml); methotrexate (2.75 mcg/ml); mitomycin-C [Mutamycin] (2.7 mcg/ml); pentamethylmelamine (0.8 mcg/ml); medroxyprogesterone [Provera] (1 mcg/ml); tamoxifen (1 mcg/ml); 6-thio-TEPA (1 mcg/ml); vinblastine [Velban] (0.78 mcg/ml); vincristine [Oncovin] (0.4 mcg/ml); vindesine (0.6 mcg/ml); and VP-16 [a semisynthetic derivative of podophyllotoxin] (30 mcg/ml).

RESULTS. A summation of our efforts in cloning human tumor stem cells is presented in Table 1. These were obtained from patients with various malignant tumor types. Considering both solid tissue and fluid specimens, the cloning efficiency was 46%. However, if one considers the difference between cloning efficiency of solid tumors and effusions, the differences are striking. Table 2 presents the results of the solid tumor assays and Table 3 presents the results when malignant effusions were used as the source of tumor cells. When considering all tumor types tested, 55/98 or 56% of the specimens from solid tumors grew in culture while 36/102 or 35.3% of the specimens from effusions grew colonies. These results do reflect the 20/102 effusions which did not have tumor cells present by direct cytological observation. If these are excluded as well as those samples which were contaminated or insufficient, the overall cloning efficiency is 58% (62% for solid tumors and 53.7% for effusions). Furthermore, the cloning efficiency varied greatly depending on the tumor type regardless of the specimen source (range 0-80%).

Correlation of the *in vitro* test results and the *in vivo* tumor response in this population is presented in Table 4. Since this was a retrospective study, only 53 samples from 47 patients were obtained and tested for drugs which were used for treating the patient. Some samples were also excluded because the patients died before adequate evaluation of tumor response could be performed, the patient refused treatment, or the patient had received so many drugs prior to testing that the results were not interpretable. The proportion of samples which showed both

Table 1—*Clonogenic efficiency*

	NUMBER	PERCENT OF TOTAL TESTED
Growth	91	46%
No growth*	85	43%
Too few cells	16	8%
Contaminated	8	4%

*Includes 20 samples with negative cytology

Table 2—*Human tumor stem cell clonogenic assay malignant tumor types—specimen source and results (TISSUES)*

	Growth	No growth	Too few cells to plates	Bacterial/fungal contamination	Totals
Brain		1			1
Breast	8	9		2	19
Gastrointestinal					
Colorectal	8	2	2	1	13
Esophagus			1		1
Gall bladder	1	2			3
Pancreas	3		1		4
Parotid gland	1				1
Peritoneum	1			1	2
Stomach	1	2			3
Genitourinary					
Endometrium	2	1			3
Ovarian	8	3		1	12
Uterine cervix	1				1
Bladder	2				2
Kidney	3	2			5
Seminoma testis	1				1
Sarcoma					
Malignant hemangiopericytoma		1			1
Myxoid liposarcoma		1			1
Mesenchymal chondrosarcoma	1				1
Osteogenic sarcoma	1				1
Lung	3	4			7
Malignant melanoma	5	1			6
Lymphoma	1	2			3
Plasmacytoma		1			1
Unknown primary	4	2			6
	55	34	4	5	98

Table 3—*Human tumor stem cell clonogenic assay malignant tumor types—specimen source and results (FLUIDS)*

Tumor Type	Growth			No growth		Too few cells to plate		Bacterial/ fungal contamination		Totals
	A*	P	PC	A	P	A	P	A	P	
Breast	3	10		3 (3)**	4 (1)	1	1		1	23
Gastrointestinal										
Colorectal	1			3 (2)						4
Esophagus						2				2
Liver (hepatoma)				3 (3)						3
Pancreas	1			1	1 (1)	3				6
Stomach				1	1 (1)					2
Ovarian	3	5		2	3					13
Lung		12	1		23 (6)		3		2	41
Kidney					2					2
Malignant melanoma					1					1
Unknown primary				1 (1)	2 (2)	1	1			5
	8	27	1	14 (9)	37 (11)	7	5	0	3	102

*A = ascitic fluid; P = pleural fluid; PC = pericardial fluid.
** = numbers in parentheses are samples with negative cytology for tumor cells.

in vitro sensitivity and *in vivo* tumor response was 68%; the portion which showed *in vitro* resistance and the tumor did not respond was 88%. This correlation was highly significant at the P = 0.0001 level.

Two interesting case reports are presented, demonstrating the utility of the HTSCA:

Case 1. A 15-year-old female had a resection of a 4-cm tumor from the left upper rib area in 1979. Multiple pulmonary metastases were noted at the time. The histology was that of a mesenchymal chondrosarcoma. She was treated with cis-platinum, adriamycin, and high-dose methotrexate from April 1979 to February 1981. Two new metastatic nodules were removed from the lungs by thoracotomy. Resistance to all three drugs was noted but the tumor was sensitive to actinomycin-D, 6-thio-TEPA, and vincristine. She was later treated with monthly cycles of vincristine, cyclophosphamide, and actinomycin D and is free of disease reoccurrence for the past nine months.

Case 2. A 59-year-old male with a diagnosis of inoperable gastric carcinoma with omental metastasis presented in August 1981. Tumor tissue cultured showed resistance to doxorubicin and low-dose mitomycin-C, but sensitivity to fluorouracil, mitomycin-C, and vindesine. He had no response to fluorouracil, doxorubicin, and mitomycin-C combination chemotherapy. He was later treated with an intravenous infusion of vindesine every two weeks and has been in complete remission for more than three months. Follow-up computerized tomographic (CT) scan of the abdomen showed disappearance of malignant ascites and tumor mass around the stomach.

Table 4—In vivo/in vitro *growth inhibition correlation*

	TUMOR RESPONSE	
HTSCA	REGRESSION	PROGRESSION
Sensitive	19	9
Resistance	3	22

In vivo/in vitro resistance = 88%
In vivo/in vitro sensitivity = 68%
$X^2 = 19.135$ P = 0.0001

DISCUSSION. It is apparent from these results, as well as others, that human tumor stem cells can be grown in culture under defined conditions. Growth of these clones or colonies are inhibitable by incubating these cells in the presence of antineoplastic drugs. The inhibition of *in vitro* colony formation appears to reflect to a large extent the response of the tumor when exposed to appropriate drug concentrations *in vivo*. The HTSCA as is described here, and as described elsewhere,[3,7] is a better predicter of resistance to a drug than sensitivity. Combined with the relatively low rate of false-negative results and the even lower rate of false-positive results, the HTSCA should be a valuable asset in the armamentarium of the clinician in treating malignant disease.

The results presented here compare very favorably with other literature reports.[8-11] The overall cloning efficiency and the present correlation of *in vivo/in vitro* results was slightly lower than others have reported. The differences are the result of limiting a report to one tumor type. The results presented here compare very favorably for such tumors as breast, colorectal, ovarian, and malignant melanoma.

The correlations presented here demonstrate a significant correlation between the *in vitro* prediction of response and the *in vivo* tumor response to therapy. These results were conservative observations of the tumor response on a retrospective basis. The HTSCA predicts resistance more effectively than sensitivity, however, this should still be a significant advantage in the selection of an appropriate chemotherapeutic regimen. Future prospective studies are required to effectively establish the reliability of this assay.

Some tumors grow more readily in culture than others. The results reported here demonstrate a marked difference in the ability to grow tumor cells depending on the primary tumor type. Empirically it appeared that more malignant tumors grew more readily in culture. This was true for both solid tumors and malignant effusions. Further studies are underway to confirm this observation.

Sample handling may well be a major concern of the HTSCA. The results presented here demonstrate a consistent increased cloning efficiency with solid tumors compared to effusions. Other reports do not support these results.[3] Since our results demonstrate that samples in which tumor cells cannot be seen by direct cytological examination do not produce colonies, further studies need to quantify the number of tumor cells required for the HTSCA. Approaches to this problem are being considered.

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Abstracts

The following abstracts are from papers presented at the Wisconsin Neurological Society meeting, May 16-17, 1981, in Green Bay, Wisconsin. Gastone G Celesia, MD of Madison, who is Secretary for Medical Education of the WNS, served as coordinating editor for these abstracts.

Lipid storage myopathy

Richard J Hodach, MD; Marjorie E Tripp, MD; Austin L Shugg, PhD; Enid F Gilbert, MD; Sunita Arya, MD; Henry A Peters, MD; Dennis J Paulson, PhD, Madison, Wisconsin

We have had the opportunity of studying four cases of lipid storage myopathy. Two of these cases were from the same family, each individual having clinical evidence of severe cardiomyopathy and minimal evidence of skeletal myopathy. Systemic and muscle carnitine levels were decreased, and lipid storage myopathy was confirmed at autopsy in one and skeletal muscle biopsy in the other. In another case, the individual presented with a progressive syndrome suggestive of Reye's syndrome, had low plasma and muscle carnitine levels and evidence of lipid storage on muscle biopsy. In the last individual, the child had evidence of mental retardation, spastic paraparesis, cardiomyopathy, and myopathy. Systemic carnitine and muscle carnitine values were normal. Skeletal muscle biopsy revealed evidence of lipid storage and abnormal mitochondria. ■

An unusual case of facial paralysis

John L Bender, MD, Rockford, Illinois

A 25-year-old, white, married lady first presented with a two-year history of gradual onset of left facial paralysis and numbness. When she was six years of age, a mass was removed from her left knee. In 1974, she underwent exploration of a left groin mass accompanied by atrophy of the left quadriceps femoris muscle and loss of sensation in the distribution of the femoral nerve. Pathological diagnosis at the time was that of a fibroma infiltrating the inguinal area and adjacent muscle and appearing to arise from fascia. On examination there was loss of corneal reflex, atrophy of temporalis and masseter muscles, diminished sensation in mandibular division of V, and weakness and atrophy of all facial muscles on the left side. There was a left-sided sensory loss from T8 to the coccyx and left femoral neuropathy. She had a firm, scar-like swelling in her left groin near the surgical scar. The skin color of her left shoulder was tan. She was admitted to the hospital and excisional biopsy of the left groin gave a tissue diagnosis of neurofibromatosis. ■

Urban leptospirosis in Milwaukee

Ludwig A Lettau, MD, Milwaukee, Wisconsin

LEPTOSPIROSIS IS A spirochaetal infection primarily affecting peridomestic and wild mammals. Man is an incidental and nonessential host infected either directly from animal contact or more commonly, via contact with urine-contaminated soil or surface waters. Leptospirosis appears to occur rarely in Wisconsin. Only five cases have been reported to the Wisconsin Laboratory of Hygiene in Madison in the last 25 years.

We recently cared for a patient with leptospirosis acquired in metropolitan Milwaukee who demonstrated many clinical and pathological features of the severe hepatorenal form of the disease (Weil's disease). We review this case to remind physicians of the key epidemiologic, diagnostic, and therapeutic features of this underappreciated acute infectious disease.

CASE REPORT. A 31-year-old black male construction laborer was in excellent health until four days prior to admission to the hospital. After a particularly strenuous work day he noted onset of severe myalgias, headache, and nausea. Two days prior to entry an evaluation at an emergency room revealed total bilirubin 17.2 mg/dl, slightly elevated serum glutamic oxaloacetic transaminase, serum creatinine 4.6 mg/dl, urea nitrogen 41 mg/dl, hematocrit 37%, total white blood cell count 12,600 with 54% neutrophils and 26% bands. He refused admission and two days later presented to the hospital with continued myalgias, nausea, and headaches, as well as anorexia, fatigue, photophobia, neck stiffness, dark urine, pruritus, right knee arthralgia, and a dry cough. He denied fever, chills, night sweats, vomiting, or diarrhea.

His job in the previous weeks had involved carrying buckets of roofing tar during construction of a new warehouse roof. He denied seeing rats in the work area but traps were present. He had been splashed with some stagnant water from a tipped barrel about a week prior to the onset of his illness. He denied recent recreational camping or swimming and there was no exposure to pets or other animals. He consumed large quantities of alcohol on occasion but denied intravenous drug abuse. Family history was significant for a niece with sickle-cell anemia.

Physical examination revealed a lethargic, muscular, young adult black male. Vital signs: blood pressure 108/60 mmHg, pulse rate 110 beats per minute, respiratory rate 16 per minute, and temperature 37 C. He was noted to have bilateral scleral icterus and conjunctival injection, diffuse minimal adenopathy, a liver span of 10 cm, and tenderness of the paraspinal, shoulder girdle, and thigh muscles.

The hematocrit was 35%; white blood cell count 14,000/cu mm with 86% neutrophils, 3% band forms, 2% lymphocytes, and 9% monocytes. Erythrocyte-sedimentation rate was 115 mm/hr. Serum chemistries: blood urea nitrogen 53 mg/dl and creatinine 5.3 mg/dl. Liver function: total bilirubin 15.7 mg/dl (direct 13.6 mg/dl), serum glutamic oxaloacetic transaminase 79 IU/L (normal 4-36), serum glutamic pyruvic transaminase 42 IU/L (normal 9-48), and alkaline phosphatase 53 IU/L (normal 20-120). Creatine phosphokinase was 1287 IU/L (normal 30-200). Rheumatoid factor (+) 1:320. Tests for total hemolytic complement level, antinuclear antibody, and rapid plasma reagin were normal. Urinalysis: 3+ proteinuria, 0-1 red blood cells per high-power field, 4-10 white blood cells per high-power field, and many coarse, waxy, and hyaline casts. An electrocardiogram was suggestive of pericarditis.

On the second hospital day the patient's temperature rose to 39.9 C associated with chills, diaphoresis, vomiting, and frontal headache. Lumbar puncture revealed 134 white blood cells/cu mm (89% polymorphonuclear, 11% mononuclear) and 14 red blood cells/cu mm. Cerebrospinal fluid glucose was 70 mg/dl and protein was 38 mg/dl. Chloramphenicol was started. Biliary tract ultrasound was normal. On the fifth hospital day total bilirubin peaked to 24 mg/dl (direct 15.5 mg/dl) and the patient began to feel better. Leptospirosis was suspected and antibiotics were changed to penicillin. Clinical improvement continued although the leukocytosis persisted (peak white blood cells 23,200) and anemia worsened (nadir hematocrit 28%) until the tenth hospital day. At discharge on the twelfth hospital day, hepatorenal function had almost normalized. Urine culture on Fletcher's medium for leptospirosis was negative after seven weeks, but acute and convalescent serology confirmed leptospirosis (Table 1).

From the Milwaukee County Medical Center: Department of Medicine, Division of Infectious Diseases, Veterans Administration Medical Center, and Medical College of Wisconsin, Milwaukee. Reprint requests to (current address): Ludwig A Lettau, MD, 2318 Lemon St, Metairie, LA 70001. Copyright 1982 by the State Medical Society of Wisconsin.

Table 1—*Leptospirosis microscopic agglutination titers (CDC—Leptospirosis Reference Laboratory)*

LEPTOSPIRAL ANTIGEN	TITERS	
	9/12/81 (8th day of illness)	*10/1/81 (28th day of illness)*
Ballum	1:50	1:400
Copenhageni	1:800	1:6400
Antumnalis	1:100	1:400
Mankarso	1:3200	1:6400
Ft Bragg	1:400	—
Andamana	1:800	1:200
Pyrogenes	—	1:200
Pomona	—	1:50

DISCUSSION. Early descriptions and concepts of leptospirosis have only been clarified in the last 15 to 20 years. Classically it was always a severe febrile, icteric illness resulting from occupation-related rat exposure. It was also widely held that specific serotypes caused distinctive clinical presentations of leptospirosis (*eg*, Fort Bragg fever). It is now appre ciated that (1) relatively mild anicteric cases con stitute 85% to 90% of recognizable human leptospirosis,[1] (2) dogs are the most common source of human infection in the USA,[1] (3) avocational activities outnumber occupation as the means of exposure,[1] and (4) all serotypes can cause a spectrum of illness although some (*eg*, L. icterohaemorrhagiae) can more often be associated with severe icteric illness than others. Only about 100 cases of leptospirosis are reported per year to the Centers for Disease Control (CDC),[2] but because of the high percentage of mild cases, the reported incidence probably markedly underestimates the real incidence of disease.

Our patient most likely acquired his infection via contact with rat-contaminated water on the warehouse roof where he had been working. Rat-associated urban outbreaks of leptospirosis have been reported from Oregon[4] and St Louis.[5] Unquestionably peridomestic rat populations remain the most important urban reservoir of leptospirosis. A survey of the Detroit rat population in 1975 revealed more than 90% of rats infected with the L. icterohaemorrhagiae serotype.[6]

Clinical and laboratory features of leptospirosis have been well reviewed in detail elsewhere.[1] Our patient had a typically acute onset of severe myalgias, headache, vomiting, photophobia, and conjunctival suffusion. Early onset of jaundice and azotemia were indicators of severe illness, and progression to aseptic meningitis was typical. Laboratory data classic for severe leptospirosis were also seen in our patient including neutrophilia, anemia, elevated erythrocyte-sedimentation rate, direct hyperbilirubinemia (with relatively normal serum glutamic oxaloacetic transaminase/serum glutamic pyruvic transaminase), elevated creatine phosphokinase, azotemia with an active urinary sediment, cerebrospinal fluid changes of aseptic meningitis, and electrocardiographic changes suggesting pericarditis. Individually these data are nonspecific, but collectively they should be very suggestive of leptospirosis. In particular the above pattern of liver dysfunction in the presence of creatine phosphokinase elevation should strongly favor leptospirosis as emphasized by Johnson, et al.[7]

Leptospirosis is a great mimicking disease in the class of syphilis and malaria and the differential diagnosis is lengthy. The biggest hurdle to the diagnosis is to think of it. However, rapid definitive bacteriologic diagnosis is very difficult as direct dark field examination of blood, cerebrospinal fluid, tissue, or urine is of low sensitivity and specificity. Leptospires are relatively easy to culture on appropriate media, but cultures may take several weeks to become positive.

Most patients are diagnosed serologically. Antileptospiral antibodies appear on the sixth to twelfth day of illness and peak in the third week. CDC criteria for a serologically confirmed case are either a seroconversion from a microscopic agglutination (MA) titer of $< 1:50$ to 1:200 or greater, or a 4-fold or greater change in the MA titer between acute and convalescent sera studied at the same reference laboratory.[3] Our patient fulfilled the latter criterion and his highest convalescent MA titers of 1:6400 were to the copenhageni and mankarso antigens indicating his infecting leptospire to be in the L. icterohaemorrhagiae serogroup. This is very consistent with rat-associated infection.

Antibiotic therapy consisting of penicillin or tetracycline is probably beneficial only if given in the first few days of illness and may ameliorate hepatorenal complications. Full and comprehensive supportive therapy, including peritoneal or hemodialysis if necessary, is indicated since all organ dysfunction is fully reversible with time.

SUMMARY. We have presented a patient with the classic severe hepatorenal form of leptospirosis acquired most likely via occupation-related rat exposure. Key features of the epidemiology and diagnosis of this disease have been discussed.

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Feds approve gatekeeper system, questions remain

Federal Health and Human Services Secretary Richard Schweiker November 9 approved a State Dept of Health and Social Services request for a waiver from freedom of choice requirements under the Federal Medicaid law. The waiver would allow community mental health services boards to act as gatekeepers of mental health services provided in both inpatient and outpatient settings.

The Federal decision neglected to comment on Federal District Judge Barbara Crabb's conclusion in a recent State Medical Society/Wisconsin Psychiatric Association lawsuit that physician services, including those of psychiatrists, are mandated under a state Medicaid program.

Secretary Schweiker ordered the state to amend the Wisconsin program because large amounts of Federal dollars are currently being used illegally to fund persons age 22 to 64 in certain inpatient treatment settings. The State had originally secured the counties' endorsement of the gatekeeper system by allowing them to capture additional Federal money in order to offset some of their own inpatient costs.

At the November 13 SMS Board of Directors Meeting, the Society's Executive Committee informed the Board that it intends to pursue the following plan relating to the gatekeeper concept. The Executive Committee will:

- Seek repeal of enabling legislation through amendments to the Governor's Budget Bill or in separate legislation.
- Conduct an intensive several-month study of the quality effects of the gatekeeper system in order to be able to further substantiate the Society's claims in court.
- Seek the assistance of the American Medical Association and the American Psychiatric Association as possible participants through amicus curiae briefs due to the national implications of the outcome of the Society's legal action.
- Explore the possibility of further motions in both State and Federal court. ■

More Board of Directors Action November 13

In other action Saturday morning, November 13, the SMS Board of Directors:

- Referred to the Commission on Governmental Affairs a proposal of the Section on Ophthalmology for possible SMS legislative action to amend the *optometry* law to require referral of pathologic conditions to a "medical eye specialist."
- Approved a survey on physician involvement with patients who may have experienced premenstrual syndrome. The survey will be distributed and returned through meetings of the SMS Board of Directors, Society commissions and committees, and some county medical societies.
- Returned to the SMS Section on Surgery for further study a proposal outlining qualifications for membership in the Section on Surgery.
- Appointed Stephen D Hathway, MD, Green Bay, to the SMS Liaison Committee on Health Care Costs; Peter L Eichman, MD, Madison, and Jack D Edson, MD, Eau Claire, to the Mental Health Committee; and Mrs Robert K Ortwein, Racine, as Auxiliary representative on the Committee on Aging and Extended Care Facilities. ■

A day in the life of SMS President Kempthorne

Before 1982 comes to an end, SMS President Gerald C Kempthorne, MD will have made nearly 30 medical society or other organization meetings during the last six months. What's it like to be president of the State Medical Society? Let's look at a recent example of Doctor Kempthorne's travels in Western Wisconsin October 18-20.

After spending most of the morning seeing patients in your office in Spring Green, you get into your car for the three-hour drive to La Crosse. At 2:30 pm you and SMS Field Representative Paul Jacobson meet with the representatives of the Gundersen Clinic; from there you go on to the Skemp-Grandview-La Crosse Clinic to meet with its clinic manager.

From 5:15 to 6:30 pm you are interviewed by reporters from WKTY Radio and WKBT-TV in La Crosse on topics ranging from impaired physicians to Medicaid and physician fees.

That evening, you are the featured speaker at the La Crosse County Medical Society meeting. Here, too, you are interviewed by a radio reporter from WLCX in La Crosse and at 9:00 pm by a *La Crosse Tribune* reporter.

Tuesday, October 19, begins with an interview at WXOW-TV in La Crosse. At 10 am you make a courtesy call to a local physician who had additional questions to ask you regarding your speech the night before. From there you go on to the La Crosse Family Practice Clinic to meet with staff physicians and tour the facility. At 11:30 am it's another radio interview with WIZM in La Crosse.

You get a quick lunch and travel on to Mondovi to meet with a local physician there at 1:30 pm. You travel on to Eau Claire and by 3:00 pm meet with the Director of the Eau Claire Family Practice Clinic. That eve-

ning, you speak to the Pierce-St Croix County Medical Society. End of day two.

Day three begins at 9:30 am with a meeting with the President of the Eau Claire-Dunn-Pepin County Medical Society. At 10:30 am you are interviewed by WQOW-TV in Eau Claire.

The Auxiliary Fall Board meeting is next on your agenda where you speak to state and county auxiliary leaders on the SMS Impaired Physician Program. A reporter from the *Eau Claire Leader Telegram* is present and you consent to an interview.

Following the Auxiliary luncheon at 1:30 pm you get back in your car for the four-hour ride home to Spring Green. ■

CES FOUNDATION

CONTRIBUTIONS—SEPTEMBER 1982

The Charitable, Educational and Scientific Foundation of the State Medical Society is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for September 1982.

Nonrestricted

Carroll A Bauer, MD; BA Trimborn, MD; Eau Claire-Dunn-Pepin County Medical Society Auxiliary; SMS Members—*Voluntary Contributions*

Restricted

John T McEnery, MD; Erwin P Ludwig, MD; Mrs Edwin H Ellison; Mrs Wm D James; Katherine G Webster; John T Mendenhall, MD; RD Fritz, MD; Judith Langheim; Albert P Graham, MD; Jacqueline A Dunger—*Aesculapian Society Dues*

State Medical Society—*Wisconsin Work Week of Health*

Russell S Pelton, MD; DM Connors, MD; Mrs RE Garrison; Jane E Edson—*Aesculapian Society Dues (Museum of Medical Progress Endowment Fund)*

Memorials

Mr-Mrs HB Maroney II—*Mr Eugene C Craven (BS Maroney Fund)*

Mark H Ingraham; Vera H Myers; Patricia S Kaeser; Edward C Jones; Mrs Marion Palmer Crownhart; Mr-Mrs Reed Coleman; Dr-Mrs Arthur Holbrook; Mr-Mrs WJ Bury; Roy and Rea Ragatz; Robert BL Murphy; Wm T Russell, MD; Mrs Joseph W Vilas ; Leroy A Johnson—*H Kent Tenney, MD*

Leroy A Johnson; Mrs Marion Palmer Crownhart; Dr-Mrs EJ Nordby; Robert BL Murphy—*Frank L Weston, MD*

Dane County Medical Society; Dr-Mrs EJ Nordby—*David J Noll, MD*

Wm T Russell, MD—*Agnes Hill; John Sprague, MD*

Farrell F Golden, MD—*JJ Saxe, MD*

Dr-Mrs EJ Nordby; Dr-Mrs Farrell F Golden—*John V Berger, MD* ■

Leadership Conference hailed a success

If attendance and enthusiasm are any indication, then the 1982 Leadership Conference November 12-13 at the Brookfield Marriott was a resounding success. Approximately 125 physicians representing county medical societies, specialty societies, SMS commissions and committees, and Society officers and directors participated in the two-day program intended to explore a number of current and expected trends in medicine and healthcare.

A featured speaker at the meeting was American Medical Association Executive Vice President James H Sammons, MD who spoke on a pot pourri of issues currently facing the profession, ranging from the Federal Trade Commission's authority over the professions to peer review and financing healthcare.

Doctor Sammons said now is not the time to relax in the FTC fight. "It has been clarified that the FTC has the right to interfere with such activities as credentialing and the certification processes," he said.

The AMA EVP also expressed concern over the future of peer review. While the PSRO (Professional Standards Review Organization) concept worked well in Wisconsin, experience across the country was not so good and the AMA supported efforts to abandon the PSRO concept. "With the advent of the Durenburger Bill, however, it appears that the only concern of government in the future will be the cost of care—not quality," Doctor Sammons said.

"We have a moral obligation to see that the quality of care is practiced at all costs," he reminded physicians.

A more detailed report of the conference will appear in the January issue. ■

Division of Health staff hears from Doctor Kempthorne

SMS President Gerald C Kempthorne, MD addressed 500 employees of the State Division of Health October 21 at a one-day division-wide informational meeting held at the UW-Madison Memorial Union. Doctor Kempthorne, who was one of the featured speakers on the program, spoke on improving relations between organized medicine and government.

"I am convinced that organized medicine is ready and willing to develop a much better working relationship with government. In view of the many mutual problems, I can see no other alternative," he said.

The SMS President told the DOH staff and its Secretary Donald Percy that he intends to "knock on the door" of the next governor to offer physicians' services to improve the healthcare system of Wisconsin. ■

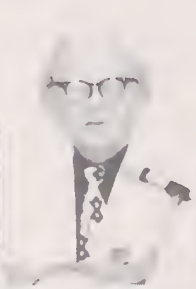
Senior physicians have second annual meeting

Nearly 50 physicians and some of their spouses attended the second annual meeting of the Wisconsin Association of Senior Physicians held at SMS headquarters in Madison, October 9.

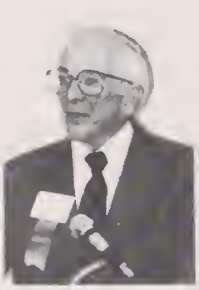
The one-day event was chaired by Norman M Clausen, MD, Mazomanie, president. The moderator was Paul J Collopy, MD, Milwaukee, president-elect. The attendees were given some helpful information by the following guest speakers:

Professor Robert Schacht, professor of adult education, University of Wisconsin-Madison Extension, spoke on "Add Life to Your Years with Travel." John Secord, vice president and manager of the Madison Branch of The Milwaukee Company, a brokerage firm, keyed in on "The Current Economic and Market Environment" while Robert Karlman, vice-president and manager of financial planning for The Milwaukee Company, ad-

Dr Paul Collopy


Prof Robert Schacht

Prof Arthur Peterson


John Secord

Robert Karlman

Dr Joseph Benforado

Identifiable in top row: Mrs and Doctor Chris J Buscaglia, Dr Nels A Hill, and Dr Henry A Anderson

Dr Norman Clausen

Dr and Mrs Eugene Eckstam

Dr George Handy

Dr Thomas Leonard

dressed the issue of "Financial Planning for the Retirement Years."

Professor Arthur Peterson of the University of Wisconsin-Madison Soils Department, spoke on "The Holy Land" and Joseph M Benforado, MD, professor in the Department of Medicine, University of Wisconsin-Madison, concluded the program with an "Outlook in Drug Abuse."

The group also elected officers for the ensuing year as follows: Paul J Collopy, MD, Milwaukee, president; Howard L Correll, MD, Arena, president-elect; and Edward A Bachhuber, MD, Mayville, secretary-treasurer.

Participants viewed a number of exhibits displaying hobbies of senior physicians, including those of Thomas A Leonard, MD, Middleton (scissors collection); Guy M Carlson, MD, Madison (paintings); James E Albrecht, MD, Jackson (handcrafted pottery); Harvey L Burdick, MD, Milton (water colors and photography); Erwin J Jelenchick, MD, New Berlin, and Lester E Haushalter, MD, Brookfield.

All physicians age 60 years or over, who are members of the State Medical Society of Wisconsin and are retired, or semi-retired, are eligible to join the Wisconsin Association of Senior Physicians and become active participants. Interested physicians should contact Bill Wendle at SMS headquarters. (Staff photos by Bill Wendle)■

WISCONSIN SENIOR PHYSICIANS CONVENTION—ATTENDEES, Saturday, October 9, 1982

Henry A Anderson, MD, Madison
James H Barbour, MD, Oshkosh
James H Biller, MD, Milwaukee
Benjamin I Brindley, MD, Madison
Frederick Bunkfeldt, MD, Elkhart Lake
H Laurence Burdick, MD, Milton
Chris J Buscaglia, MD, New Berlin
Donald W Calvy, MD, Wauwatosa
Guy W Carlson, MD, Madison
Homer M Carter, MD, Madison
Kenneth L Carter, MD, Beloit
Norman M Clausen, MD, Mazomanie
Paul J Collopy, MD, Milwaukee
James E Conley, MD, Milwaukee
Howard L Correll, MD, Arena
Isidoru Z Davidoff, MD, Santa Monica, CA
Jean P Davis, MD, Westfield
Christopher R Dix, MD, Elm Grove
John P Docktor, MD, Grafton
Eugene E Eckstam, MD, Monroe
Ted D Elbe, MD, Thiensville
Jane H Koll-Frazier, MD, Fond du Lac
Samuel L Gabby, Jr, MD, Milwaukee
George R Hammes, MD, Wausau
George H Handy, MD, Madison
Horace J Hansen, MD, Sheboygan Falls
Theodore L Hartridge, MD, Madison
Lester E Haushalter, MD, Brookfield
Howard C High, MD, Milwaukee
Nels A Hill, MD, Madison
Willard G Huibregtse, MD, Sheboygan
Erwin J Jelenchick, MD, New Berlin
August J Jurishica, MD, Milwaukee
Ken Kincaid, MD, Madison
Howard M Klopf, MD, Brookfield
Thomas A Leonard Jr, MD, Middleton
Russell F Lewis, MD, Marshfield
B Jack Longley, MD, Madison
John D Lynch, MD, Manitowoc
Eugene J Nordby, MD, Madison
Margaret Prouty, MD, Madison
Karver L Puestow, MD, Madison
William T Russell, MD, Sun Prairie
Harold H Scudamore, MD, Monroe
Eugene E Skroch, MD, Madison
Alice D Watts, MD, Oregon
Amy Hunter-Wilson, MD, Madison■

Dr Scott to head North Central Medical Conference

James K Scott, MD, Madison, has been named president-elect of the North Central Medical Conference. His election occurred October 31 when the six-state medical group—Wisconsin, Minnesota, North and South Dakota, Iowa, and Nebraska—met in Minneapolis. Doctor Scott, an otolaryngologist, is also a Wisconsin delegate to the American Medical Association.

During the meeting, Gerald C Kempthorne, MD, Spring Green, discussed the Wisconsin Statewide Impaired Physician Program emphasizing its unique organizational structure, statewide confidential hot line, its extensive intervention program, and coordination with the Medical Examining Board.

Kenneth M Viste Jr, MD, Oshkosh, chairman of the Society's Physicians Alliance Commission, discussed Wisconsin's professional liability program. He urged continued support and improvement of the program, including compensation panel changes which would speed up the formal and informal processes regarding malpractice allegations.

William M Kraus, Secretary of the Wisconsin Department of Development and former aide to Governor Dreyfus, outlined his perceptions of medical care. "Politicians feel confused and cornered by the complexity of the healthcare system and pressed to find a cost-containment solution." He concluded that they "will find a way out of the box—something they are very skillful at."

At the conference, Cyril M Hetsko, MD, Madison, served on the resolutions committee and Richard W Edwards, MD, Richland Center, served on the nominations committee. Also attending the conference from Wisconsin were Cornelius A Natoli, MD and Pauline M Jackson, MD, La Crosse and J D Kabler, MD, Madison.■

Physician-citizens of the year honored

Three Wisconsin physicians have been chosen as 1982 "Physician-Citizens of the Year" by the State Medical Society of Wisconsin and the Wisconsin Chambers of Commerce Executives Association.

Warren H Williamson, MD, Racine; John N Richards, MD, Kenosha, and Gordon L Backer, MD, Wausau, were recognized in separate ceremonies in October for their outstanding contributions to their communities and patients. Among the criteria used in selecting award recipients was how each contributed to the betterment

Doctor and Mrs Backer and Doctor Park

Doctor Williamson

Doctor Richards

of his community and nation, to the public understanding of the role of medicine, and to the better health and improved quality of life for Wisconsin patients.

Dr Warren H Williamson was honored October 21 at an evening meeting of the Racine County Medical Society at the Meadowbrook Country Club in Racine. Racine County Medical Society President VA Baylon, MD presented him with the award.

Born and raised in Racine, Doctor Williamson has practiced family medicine in that community for 33 years. A graduate and class president of Racine Horlick High School, he received his undergraduate and medical degrees from Northwestern University.

Since Doctor Williamson established his family practice in Racine in 1949, he has been a key figure in local civic affairs and in the medical community.

In the area of organized medicine, Doctor Williamson has served as president of the Racine County Medical Society and as a member of its Executive Committee for ten years. He continues to serve the medical community in a tireless fashion and most recently, has been involved in establishing a coalition of physicians, labor, and business representatives to work toward containing medical costs. At the same time he has been busy organizing a seminar for local school officials and teachers on the mental and physical effects of the use of marijuana.

At the state and national level he has been a delegate to the State Medical Society of Wisconsin for three years, and was an alternate delegate to the American Medical Association from 1978 to 1982.

Doctor Williamson has helped to assure that the health needs of Wisconsin's jail population are met through his participation in the State Medical Society of Wisconsin and American Medical Association's Jail Health Care Program. Currently, he serves as chairman of the State Medical Society committee overseeing the project as well as on the Society's Committee on Alcohol and Other Drug Abuse.

Notwithstanding the fine leadership which he has provided and continues to provide in the medical field, Doctor Williamson's greatest accomplishments lie in his activities involving civic affairs.

Early in his career Doctor Williamson successfully ran for election as a member of the governing board of trustees for the Village of Wind Point.

In 1966 he was a co-founder and later president of the Racine A-Center, a treatment facility for alcohol and drug abusers. At the time of its organization, Doctor Williamson was personally responsible for the development of its treatment plans and for the establishment of a medical staff at the facility. Today, the A-Center is recognized as one of the finest facilities of its kind, and Doctor Williamson continues to serve on its board of directors.

A past president of the Racine Area Chamber of Commerce, Doctor Williamson, at the request of the Mayor of Racine in 1973, served as chairman of the Central City Redevelopment Committee for the Greater Racine area from 1973 to 1976. As chairman of this committee, Doctor Williamson personally coordinated the effort to develop a comprehensive plan for the revitalization of the deteriorating central city. Today, that plan is being used as a guide for the city's current efforts to renovate its downtown area.

Doctor Williamson's efforts in his local community have not gone unnoticed. In 1974 he received the "Racine Citizen of the Year Award" from the Veterans of Foreign Wars, and in 1979 he received the Distinguished Service Award of the Kiwanis Club of Racine.

As one colleague recently put it: "There are usually a few people in each community, who, because of their untiring efforts, are the true moving forces behind every significant community accomplishment. Doctor Williamson is such a force in our local community. The citizens of Racine are indebted to him for his efforts."

Dr Gordon L Backer received his honor at a noon luncheon of the Wausau Area Chamber of Commerce and Marathon County Medical Society, Thursday, October 21 at the Wausau Club in Wausau. SMS Director

Jung K Park, MD, Wisconsin Rapids, presented the award.

Gordon L Backer, MD established his ophthalmology practice in Wausau in 1963 following his residency at the Mayo Clinic in Rochester, Minnesota. After receiving his undergraduate degree from Macalester College in St Paul, Minnesota and his medical degree from the University of Minnesota Medical School in 1955, he went on to serve as a flight surgeon in the US Navy from 1956 through 1958.

Because of contributions to both his community and his patients, Doctor Backer has been called "one of Wausau's finest citizens."

An active member of the Wausau Area Chamber of Commerce, Doctor Backer has held a variety of leadership positions with the organization including serving as an officer from 1977-80, and as chamber president during 1978-79.

Currently he is chairman of the Downtown Redevelopment Council, a Chamber committee dedicated to maintaining a strong and viable downtown. He is also vice president of the Central Wausau Progress, a 50-member group of community and governmental leaders which deals with problems affecting Wausau's business district.

In 1978 he played a key role in the passage of a downtown mall referendum which led to development of a $50 million mall, built with private and public funds, and he presently chairs a special mall integration task force which works to tie in the mall with surrounding downtown businesses. Doctor Backer also has served on the Marathon County Economic Development Council from 1979 to 1980. The council works to attract industries to Marathon County and helps existing plants expand.

Doctor Backer has been a strong advocate for improved healthcare services for Wausau citizens. In 1974 he helped found the community Health Coordinating Council with a purpose of bringing medical practitioners together in a forum to deal with community health needs. Since its establishment, this group has: (1) developed an Emergency Medical Plan for Marathon County ensuring adequate emergency services to all residents; (2) had a role in consolidating Wausau Hospital North and South into the new Wausau Hospital Center; (3) established the Family Practice Residency Program in Wausau; and (4) developed a dental hygienist program at North Central Technical Institute with the Marathon County Medical Society.

In addition, Doctor Backer has been a strong promoter of the vision program of the Wausau Lions Club which involves the reuse of old glasses for underprivileged children.

Doctor Backer has done much to expand the Wausau public's understanding of medicine and health education. He has delivered numerous talks on eye care topics before community groups, has assisted in glaucoma screening for the elderly, and has instructed Wausau Fire Department personnel on procedures in dealing with eye injuries.

In the area of organized medicine, Doctor Backer has been a member of the Marathon County Medical Society, State Medical Society of Wisconsin, and the American Medical Association since he came to the Wausau community in 1963. He has served as a delegate to the State Medical Society and has been very active in its Section on Ophthalmology.

"The citizens of Wausau have an improved quality of life because of the efforts of Dr Gordon Backer. Without question his dedication and concern for the city, its residents, and its healthcare have made Wausau a better place in which to live."

Dr John N Richards received his award during the Annual Meeting of the Kenosha Area Chamber of Commerce October 26 at the Elks Club in Kenosha. Kenosha County Medical Society President L H Huberty, MD presented the award.

The son of a physician, Doctor Richards is a native of Kenosha and has practiced there since 1952. He received his undergraduate and medical degrees from the University of Wisconsin, and following his residency at University Hospitals in Madison, he served two years in the US Army.

Throughout his 30 years of practice in Kenosha, Doctor Richards has been a credit to his community and his profession.

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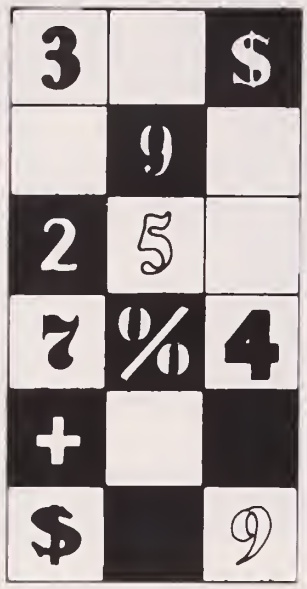

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In 1963 he led a movement to found the Kenosha Achievement Center, a sheltered workshop and vocational rehabilitation center for developmentally disabled adults. The vocational training and work experience these individuals receive at the center allow them to assume a more productive and independent role in society. In addition, the center operates the "Friendship Camp," which provides developmentally disabled children with developmental programs during the summer. For seventeen years Doctor Richards served on the center's governing board and today remains on the executive committee and serves as chairman of the personnel committee.

"Doctor Richards has been instrumental in not only acting as Kenosha's local 'goodwill ambassador' for the disadvantaged people in our community but also he has been very active in fund-raising for their programs. Through his efforts the Kenosha Achievement Center has grown from a small office with a staff of 1.5 persons and a budget of $8,000 serving 25 clients in 1963 to a two-campus complex with a staff of 50 and a budget of $1.8 million serving 900 persons in 1981. Each year he spearheads an annual golf outing for the center which last year showed a profit of $19,999."

Doctor Richards has played a significant role in developing the Comprehensive 51.42/.437 Board of Kenosha County. This is the sole body in the county responsible for planning and seeing that services and care are provided to local citizens in the areas of mental illness, alcohol and other drug abuse, and developmental disabilities. A charter member of the Board, Doctor Richards currently serves as vice chairman of the developmental disabilities committee and chairman of the program services committee.

A physician advisor to the Special Olympics in Kenosha, Doctor Richards maintains an informative and active role in both the local and state board of the Association for Retarded Citizens. His strong and visable advocacy on behalf of retarded citizens has served as both an example and inspiration for the entire community.

He is a lifelong member of St Mark's Catholic Church in Kenosha, where he most recently was elected vice president of the parish council. He has also been an active participant in United Way campaigns, the Boy Scouts of America, United Cerebral Palsy of Kenosha County, the New Concepts Foundation of Wisconsin—which has organized 75 group homes around the state, and the Kenosha Community Relations Council—an organization working for civil rights equalities.

Doctor Richards' many activities have also involved the medical community. A past president of the Kenosha County Medical Society and the Wisconsin Urological Society, he has served as chief-of-staff at both St Catherine's and Kenosha Memorial hospitals.

"Doctor Richards' tremendous impact on the quality of life of the handicapped and disadvantaged persons in our community, and his dedication to his patients and to his profession, truly make him a 'home town boy' of note and distinction." ■

MEMBERSHIP UPDATE

The following physicians, by county medical society, have recently been elected to membership, or have been reelected or reinstated since publication of the Membership Directory in the January issue of the *Wisconsin Medical Journal,* with the specialty abbreviated above the name:

BROWN

OBG
Utrie, John W
1821 S Webster Ave
Green Bay WI 54301

DANE

N
Dasheiff, Richard M
2500 Overlook Terr
Madison WI 53705

EM
Horras, Roy S
202 N Gammon Rd
Madison WI 53717

CDS GS
Turnipseed, William D
4805 Tokay Blvd
Madison WI 53711

FP
Waltman, Steven E
1270 W Main St
Sun Prairie WI 53590

FOND DU LAC

EM
Brusky, William J
708 Meadowbrook Lane
Fond du Lac WI 54935

FP
De Boer, James E
481 E Division St
Fond du Lac WI 54935

FP
Ebben, David M
328 N Helena St
Campbellsport WI 53010

GP EM
Goodman, David A
430 E Division St
Fond du Lac WI 54935

R DR
Schwartau, William K
185 Cottage Ave
Fond du Lac WI 54935

GREEN

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Monroe WI 53566

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AN
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Kenosha WI 53140

FP
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Tallent Hill
PO Box 598
Kenosha WI 53141

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Gall, Warren E
1836 South Ave
La Crosse WI 54601

IM
Whiteway, Dean E
624 Gillette St
La Crosse WI 54601

ON IM
Witte, Robert S
1836 South Ave
La Crosse WI 54601

MARATHON

IM ON
Duelge, John TA
1211 Pine St
Wausau WI 54401

DR NM
Kosim, Sudjono
2907 10th St
Wausau WI 54401

N
Spurgeon, Gizelle A
2727 Plaza Dr
Wausau WI 54401

MILWAUKEE

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Axelrod, Bruce H
127 E Silver Spring Rd
Milwaukee WI 53217

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10425 W North Ave, #205
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Ghebredughil, Luul
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3365 North Lake Dr
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Marshfield WI 54449

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Marshfield WI 54449

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Marshfield WI 54449

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Marshfield WI 54449

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PD AI
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Marshfield WI 54449

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Unger, James B
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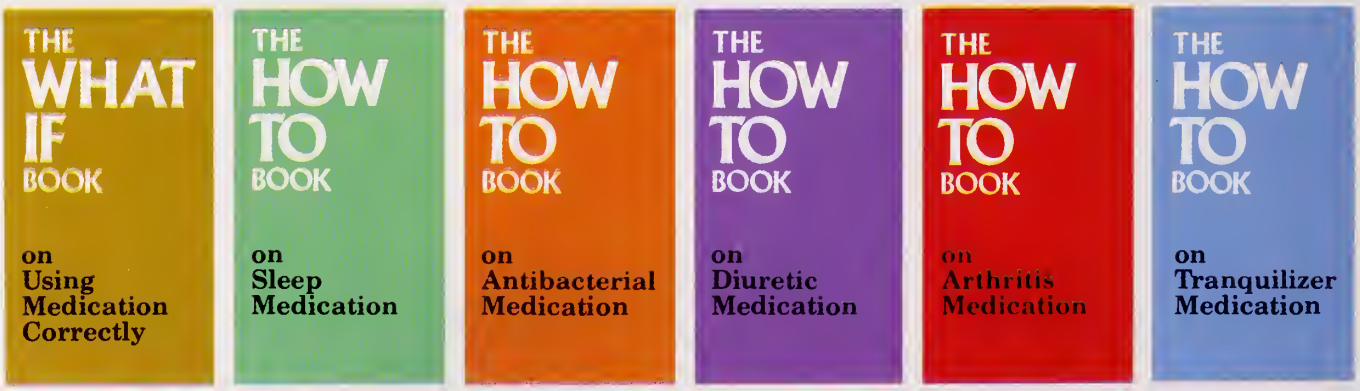

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Fond du Lac CMS uses cable TV to discuss health

Want an idea for a good county medical society communications/community health project? The Fond du Lac County Medical Society has one for you—why not tap into your local public access cable television station to discuss health and medical care topics?

The Fond du Lac County Medical Society and its Auxiliary embarked on just such a project this fall. Through the efforts of Fond du Lac County Medical Society President Douglas R Fownes, MD and SMS Physicians Alliance Field Representative Kris Bjurstrom, the county society arranged to provide a spokesperson once a month to a live "call-in show" on Lakeside Cablevision in Fond du Lac.

Every third Tuesday of the month a member of the local medical society appears with Cablevision hosts Linda Bothe and Ron Harvey to discuss medically-related topics of interest to the local Fond du Lac community.

The county society's first program aired in October with CMS President Fownes discussing what organized medicine, and specifically, the county medical society is and what it means to patients.

In November, SMS Board of Directors Chairman Darold A Treffert, MD, spoke on the new adolescent psychiatric center at St Agnes Hospital in Fond du Lac. December will feature Stephen A Massick, MD, discussing the current herpes and VD epidemic occurring nationwide.

January's program will be on brain death and also explain organ donor programs currently operating in the State. Oshkosh neurologist Kenneth M Viste Jr, MD will be the guest for this topic. February and March programs will feature the new linear accelerator at St Agnes Hospital and the infant car seat loan program initiated by the Fond du Lac Medical Auxiliary.

The live, call-in format is very informal. Viewers call in with the medical questions but are reminded by the host during every show that the physician present is not there to "diagnose," but rather to discuss the medical topic in general.

This is very important, according to Lakeside Cablevision Programming and Marketing Director Linda Bothe, in order to make the medical community comfortable with participating in the program.

"I think our program is providing a worthwhile service to community residents making people understand the ways to achieve and maintain good health and avoid illness."

She also stated that the program is helping to discourage the "MDeity" attitude many people traditionally have toward physicians. "Viewers have commented that the program is helping them see physicians as more humanistic and more approachable than they otherwise realized," Bothe says.

The program is broadcast simultaneously on KFIZ-AM radio in Fond du Lac. KFIZ is the largest radio station in the area and this fact, coupled with the approximately 11,000 subscribers to cable TV in the Fond du Lac area, make for a sizeable viewing and listening audience.

County medical societies that would like to view the programs for ideas in their communities, can get a videotape of sample programs from SMS Field Representative Kris Bjurstrom at 414/921-4407.

Appearing elsewhere in this issue is an article relating to a similar cable TV approach to health education, authored by a group of physicians from Milwaukee, one of whom is a member of the State Medical Society's Commission on Public Information.

KENOSHA: Newly elected officers of the Kenosha County Medical Society for terms beginning in 1983 are as follows: MDs Anoo P Patel,* president-elect (one-year term as p-e followed by one year as president and a one-year term as past president); Andrew T Przlomski,* secretary-treasurer (three-year term); Clifton E Peterson* and Charles E Pechous Jr,* delegates to the State Medical Society (two-year terms); and Michael Zeihen,* alternate delegate to the SMS (two-year term). All are from Kenosha. Elections were held at the November 4 meeting. Harold A Bjork, MD,* Kenosha, will succeed the current president, Lee H Huberty, MD,* Kenosha. Douglas G Devan, MD,* will continue his term as delegate and William J Jeranek, MD* and Mariano F deGuzman, MD,* as alternate delegates; all are from Kenosha.

OUTAGAMIE: Forty members were present at the October meeting of the Outagamie County Medical Society to hear John Zilavy, Green Bay; Burnell Schubbe, Neenah; and Robert Christ, Appleton, present a symposium on the cost of health care. Members also listened to Ms Barbara Nichols speak on "Current Issues in Nursing." A special presentation was made to the past president, James W Bergwall, MD,* in recognition of his dedication and service.

POLK: At the October meeting of the Polk County Medical Society, 14 members were present to hear Damon McElrath, MD, Minneapolis, MN, speak on "Adolescent Drug and Alcohol Abuse and Treatment."

MILWAUKEE: The Medical Society of Milwaukee County recently announced that effective Jan 12, 1983 William B Harlan will begin duties as executive vice-president of the Society. Since 1959 Mr Harlan has served as the executive secretary of both the Dauphin County Medical Society and the Medical Bureau of Harrisburg, Pennsylvania. His Pennsylvania experience also includes service to the Pennsylvania Society of Internal Medicine and the Pennsylvania Society of Gastroenterology. He succeeds Michael McManus who on November 1 became the chief executive officer of the Dade (Florida) County Medical Society. ■

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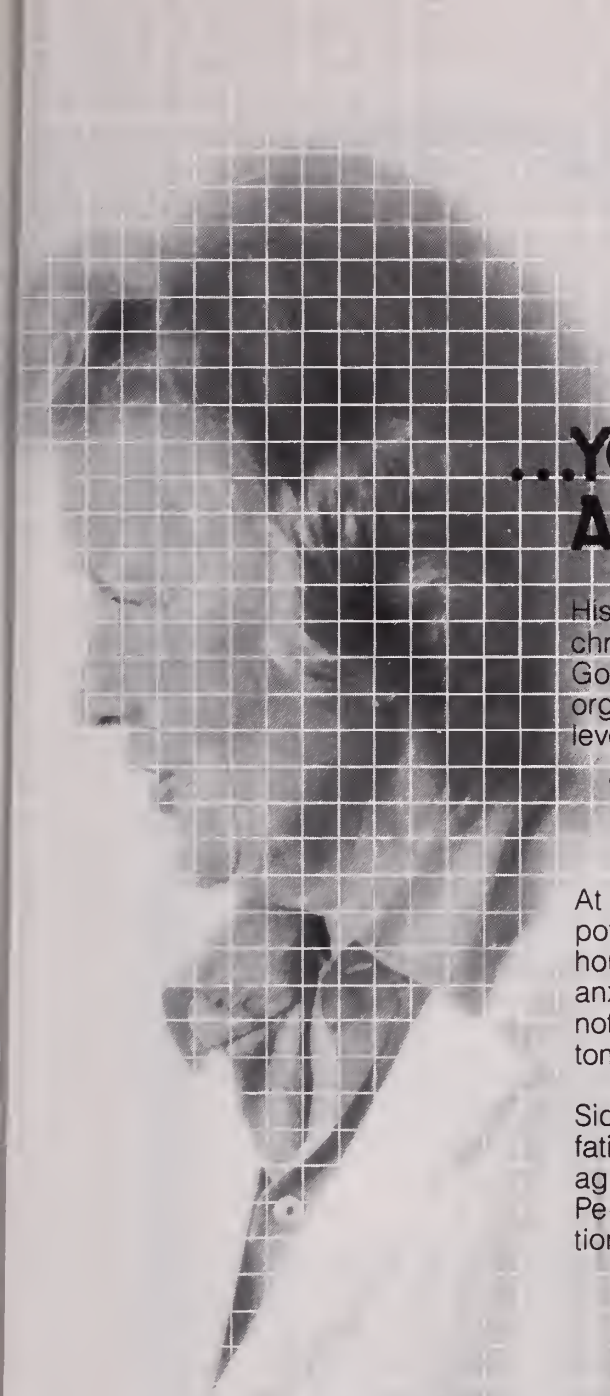

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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.
Dosage: Individualize for maximum beneficial effect. *Adults.* Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).
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Physician Briefs

*Physician members of State Medical Society of Wisconsin

Thomas H Cogbill, MD, recently joined the Gundersen Clinic medical staff in La Crosse. He graduated from the University of Colorado School of Medicine, Denver, and completed his residency at the University of Colorado Medical School.

A Scott Klein, MD, La Crosse, has joined the Gundersen Clinic in the Department of Urology. Doctor Klein graduated from the University of Michigan Medical School and completed his internship at the University of Oregon Health Science Center. His urology residency was completed at Baylor College of Medicine, Houston, Tex.

Brian R Manske, MD, radiologist, has joined the medical staff of the Gundersen Clinic, La Crosse. Doctor Manske graduated from the University of Wisconsin Medical School, Madison, and served his internship at La Crosse Lutheran Hospital-Gundersen Medical Foundation. He completed his residency at Tufts-New England Medical Center in Boston.

Robert Swenson, MD, Hayward, recently became associated with the Hayward Medical Group. Doctor Swenson graduated from the University of Minnesota Medical School and completed his family practice residency program at Hennepin County Medical Center.

Burton A Waisbren Jr, MD,* Milwaukee, recently was elected to fellowship of the American College of Cardiology. Doctor Waisbren attended Tufts University School of Medicine and served his internship and residency at Boston City Hospital. He completed his fellowship in cardiology at the Cornell-York Hospital Medical Center in New York City.

Karl Hoffman, MD, Montello, recently became associated with the Montello Medical Clinic. Doctor Hoffman graduated from the University of Wisconsin Medical School, Madison, and served his residency at St Joseph's Hospital in Milwaukee.

George M Kroncke, MD,* Madison, recently was elected secretary-treasurer of the Midwest Chest Club. A graduate from the University of Wisconsin Medical School, Doctor Kroncke is an associate professor of surgery in the Division of Thoracic and Cardiovascular Surgery at the University of Wisconsin Medical School, Madison. He also is chief of the Cardiovascular Surgery Section at the William S Middleton Veterans Administration Hospital in Madison. The Midwest Chest Club is made up of thoracic and cardiac surgeons from the states of Michigan, Ohio, Indiana, Illinois, Iowa, Minnesota, and Wisconsin. The Club was formed in 1949 and consists of 45 active and senior members.

Ronald L Smits, MD, Waupun, has opened his medical practice in the Waupun Area Medical Center. After graduating from the University of Wisconsin Medical School, Madison, Doctor Smits served in the United States Navy for three years. He completed his residency at the University of Wisconsin in Madison and had previously practiced in California for 11 years. Certified by the American Board of Dermatology, Doctor Smits is a member of the International Society of Tropical Dermatology.

Robert E Davidson, MD,* Eau Claire, recently was named medical director for the Eau Claire Academy. He has been a consulting child psychiatrist for the Academy for the past year and is chairman of the Department of Psychiatry at Sacred Heart Hospital in Eau Claire. Doctor Davidson is a graduate of the Albany New York Medical College.

Jacob Haun, MD, Portage, recently was named medical director of the Emergency Department at Divine Savior Hospital. Doctor Haun graduated from the Medical College of Virginia. Joining Doctor Haun is **Karl Hoffmann, MD,** Appleton, who has been appointed to the associate medical staff of Divine Savior. Doctor Hoffman graduated from the University of Wisconsin Medical School, Madison, and served an internship at St Joseph's Hospital, Milwaukee.

George D Mulder, MD, Sturgeon Bay, recently became associated with the medical staff of the Door County Medical Center. Doctor Mulder, a surgeon, graduated from the University of Michigan Medical School in Ann Arbor, and completed his residency training at the University of Missouri, Columbia. He was an assistant professor of surgery at the University and later had a private practice in Arkansas. Doctor Mulder is Board certified and is a member of the Marion S DeWeese Surgical Society.

Leslie G Kindschi, MD,* Monroe, (left above), recently accepted an award from John M Irvin, MD,* Monroe, (right) as "Physician of the Year" at Monroe Manor's Community Appreciation reception. Doctor Kindschi had been a member of the Editorial Board of the *Wisconsin Medical Journal* for 17 years, and a member of The Monroe Clinic since 1941. (Photo courtesy *Monroe Evening Times)*■

AMA Physician's Recognition Award Recipients

LISTED BELOW are those physicians in Wisconsin who have earned the AMA Physician's Recognition Award in recent months. The award was established in 1969 "to recognize, encourage and support physicians who participate regularly in continuing medical education and to emphasize the importance of developing more meaningful continuing medical education opportunities for physicians." A minimum of 150 credit hours of CME must be earned over a three-year period to qualify for the award. The hours may include such activities as conferences, residencies, teaching, writing, private reading, listening to cassettes, home study courses, consultation, and peer review; at least 60 of the hours, however, must be from formal CME programs sponsored or cosponsored by organizations accredited for these activities. The State Medical Society of Wisconsin congratulates the following physicians who have distinguished themselves and their profession by their commitment to continuing education:

AUGUST 1982

*Ackerman, Eugene J, Mequon
*Bauer, William, Milwaukee
*Benish, George A, Madison
*Burrill, Raymond E, Marshfield
*Falk, Victor S, Edgerton
*Fuh, Yen-Jen, Wauwatosa
*Goldberg, Henry M, Milwaukee
*Hizon, Josefina L, Sheboygan
*Janowak, Michael C, Oconomowoc
*Johnson, Raymond R, Ladysmith
Lorenzen, Kraig E, Milwaukee
*Pederson, John F, La Crosse
*Rothe, Clarence A, Green Bay
*Salibi, Bahij S, Marshfield
*Schneider, George R, West Allis
*Smith, Douglas L, Mondovi
*Sneed, Robert J, Ashland
*Toohill, Robert J, Milwaukee
Uber, Christine L, Wisconsin Rapids
*Vincent, Robert A, Oshkosh
*Wallner, Ernest F, Milwaukee
*Wunsch, Charles A, Milwaukee
Zimmerman, Donald A, Cedarburg

SEPTEMBER 1982

*Arndt, George W, Neenah
*Bernsten, Stephen A, Madison
*Bush, Robert D, Manitowoc
*Chen, Hong M, Marshfield
*Cupery, Stanley G, Beaver Dam
*Dernlan, Robert L, Manitowoc
*Frechette, Paul F, Janesville
Gima, Alfred S, Milwaukee
*Gold, Kenneth I, Beloit
Graciosa, Joseph D, Delavan
*Gromer, Rex C, Neenah
Guadagni, James R, Middleton
*Ibach, Harold F, Milwaukee
*Jasser, Mohamed K, Appleton
*Josephson, Morton, Wauwatosa
*Kaufman, Kiesl K, Milwaukee
Kayali, Bashar, Oshkosh
*Kim, Byung H, Racine
*Kim, Zaezeung, Milwaukee
*Kniaz, Albert, Milwaukee
*Layde, John P, Eau Claire
*Matzke, Robert F, Janesville
*Mikkelson, Michael K, Merrill
*Moy, Raymond W, Milwaukee
*Mueller, Howard A, Kiel
*Nair, Velayudhan K, Monroe
Ngu-Graciosa, Elena Y, Delavan
Rao, Muralidhara S, Oshkosh
*Reik, Robert P, Wauwatosa
*Rhodes, Russ A, Marshfield
*Schroeder, Daniel J, Amery
*Shaffer, Katherine A, Wauwatosa
*Shelp, Weldon D, Madison
*Tiu, Alfonso L, West Allis
*Walbrun, Fred H, Pulaski
*Woods, William C, Delavan
*Zeldenrust, John C, Two Rivers

OCTOBER 1982

*Berridge, Frank E, Milwaukee
*Bhore, Jayawant N, Milwaukee
*Boehme, Larry R, Hillsboro
*Bogle, Warren C, Brookfield
*Brazy, Robert R, Milwaukee
*Buechel, Richard L, Wausau
*Condon, Robert E, Milwaukee
Conger, David G, Sturgeon Bay
Cullen, Gerald M, Milwaukee
De Boe, Frederick M, Milwaukee
*Diba, Ali-Akbar, Milwaukee
Duffy, Thomas M, Kenosha
Factor, Robert M, Madison
*Fink, Richard A, La Crosse
*Fruchtman, Martin Z, Waukesha
*Fullerton, Donald T, Madison
*Geocaris, Thomas V, Green Bay
*Holzgrafe, Robert E, Waukesha
*Homburg, Nancy J, Appleton
*Howards, Lawrence A, Milwaukee
*Kaupie, Robert C, Wausau
*Keller, Robert A, Sheboygan
*Klasinski, Clarence A, Stevens Point
*Knezevic, Ivan D, Madison
*Lamont, Frederick J, Green Bay
*Laravuso, Raymond B, Madison
*Lewis, Russell F, Marshfield
*Morgan, William A, La Crosse
*Park, John R, Wauwatosa
*Peterson, Robert L, Waupaca
*Przlomski, Andrew T, Kenosha
Reganti, Venkata R, Neillsville
*Richards, Raymond R, Eau Claire
Roh, Byung L, New Berlin
*Rosen, Stanley R, Kenosha
*Schlernitzauer, Donald A, Manitowoc
*Schulgit, Ronald E, Cudahy
*Schuster, Donald S, Madison
Shaffer, William R, Milwaukee
*Shea, Daniel W, Green Bay
Wagner, Marvin, Milwaukee
*Weisenthal, Charles L, Milwaukee
*Wex, Thomas E, West Bend
*Zajac, Dorothy J, Janesville ■

*Members of the State Medical Society of Wisconsin

DHSS TO ISSUE PHYSICIAN MEDICAID HANDBOOKS. The Wisconsin Department of Health and Social Services will be issuing a "provider handbook" to all physicians certified in the Wisconsin Medical Assistance Program before January 1. The handbook, while designed primarily for billing personnel, will include in one source the policies and procedures of Medicaid applicable to physician services. A part of that handbook will discuss the recently implemented maximum allowable fee schedule for physician services as well as describe the criteria to be used in determining the various levels of physician office visits. This latter element is designed to supplement the procedure code descriptions used in CPT-4 and to identify what "benchmarks" are used to describe office visits for audit purposes. ■

Holy Cross Hospital, Merrill, has elected Jack D Millenbah, MD,* as its new president of the Governing Board. Doctor Millenbah formerly served as the board's vice president. He graduated from Creighton University Medical School, Omaha, Neb, and served his internship at Milwaukee County Hospital and his residency at Luther Hospital in Eau Claire.

Mercy Medical Center, Oshkosh, recently elected its officers for 1982-83. They are Johan A Mathison, MD,* president; John B McAndrews, MD,* vice president; Kenneth M Viste Jr, MD,* secretary, and William G Weber, MD,* past president. Department chiefs elected are: James L Basiliere, MD,* chief of medicine; Robert J Holly, MD,* chief of Ob/Gyn; Stephen S Dudley, MD,* chief of surgery, and John R McKenzie, MD,* chief of radiology. All the physicians are from Oshkosh.

St Mary's Hospital, Green Bay, recently was commended by the American Hospital Association for its ability to control costs and to better meet the new Medicare cost-per-case reimbursement requirements through its voluntary participation in a monthly comparative operational monitoring system. The hospital was awarded the 1983 HAS Certificate of Recognition for participating in the HAS/MONITREND management information program. St Mary's monitors its costs, employee productivity, and utilization both internally over time and in comparison to similar hospitals. The hospital has participated in the comparative management information program since 1974.

UPDATE ON PHYSICIAN FEE/MEDICAL CARE INCREASES. The rate of increase in the price of physicians' services increased 0.6% in September, according to the Consumer Price Index. The percentage increase in the all-items component was up 0.2%, the same as the all-services component, during the month. The overall medical care price index, the medical care services index, and the hospital room charge index all increased by 0.8%. For the 12 months ending with September, the physicians' services index increased by 9.0%, while the all-services index went up 7.1% and the all-items index increased 5.0%. The medical care price index increased 11.4%, the medical care services index rose 11.6%, and the hospital room charge index went up 15.3% during the 12-month period.■

SMS Placement Service aids physicians and communities

ONE OF THE MANY FUNCTIONS of the State Medical Society of Wisconsin is to assist physicians who are seeking a location to practice in Wisconsin and to assist communities seeking the services of physicians.

The Society's Placement Service maintains a continuous listing of names and biographical data on physicians who wish to locate in Wisconsin. Files are maintained on communities desiring physicians. Information is exchanged with interested physicians and communities, with the American Medical Association, and with the two Wisconsin medical schools. There is no charge to either physician or community for this service.

A list of openings is sent to physicians who contact Placement Service indicating a desire to locate in Wisconsin or to relocate within the state. A list of physicians is sent to communities requesting assistance in obtaining a physician. The physicians and communities may then contact one another. Physicians seeking associates also may request a listing of available physicians.

Experience of Placement Service shows that physicians seek locations on a long-range basis—some are available at once, while others are in residency for two or three years. One word of advice: Advise the Society's Placement Service of your needs as soon as possible. Overnight results occur but more time usually means better results.

It should be noted that Placement Service is not a recruiting effort. Its function is supported by membership in the State Medical Society of Wisconsin. The Society does, however, cooperate with the state-supported Office of Rural Health in its New Physicians for Wisconsin Program which provides placement services to communities and physicians on a fee basis determined by budgetary funds available.

Physicians and communities also may utilize the "Medical Yellow Pages" section of the *Wisconsin Medical Journal.* This classified advertising section is available to members of the State Medical Society, other physicians, communities, clinics, hospitals, recruitment firms, and others at reasonable rates.

Physicians using the Placement Service have described it as one of the most effective in the United States. *Journal* advertising, too, has proved highly successful.

Inquiries should be addressed to Placement Service, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701; tel 608/257-6781; and/or *Wisconsin Medical Journal,* Box 1109, Madison, Wis 53701.■

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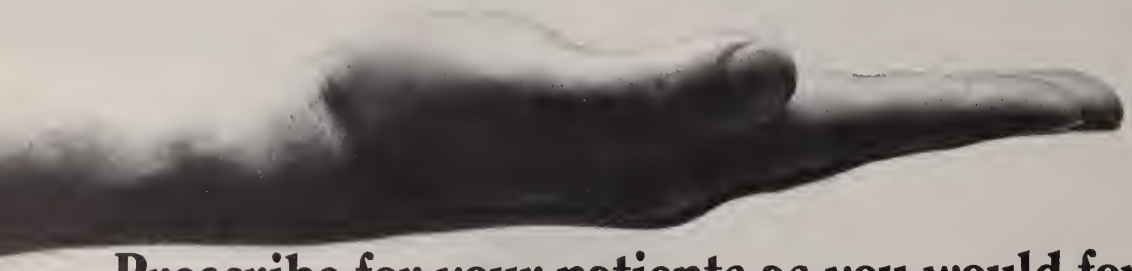

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Physicians Exchange

Obstetrics-Gynecology. Position available at the Racine Medical Clinic, a progressive cluster corporation of 25 physicians. Excellent benefits, unlimited earnings and a fulfilling practice offered. Please contact: Roger D Lacock, Administrator, Racine Medical Clinic, 5625 Washington Ave, Racine, Wis 53406; ph 414/886-5000. 9tfn/82

Family Physician or Internist with family practice interest to join physician in well established practice in southeastern Wisconsin. Excellent hospital with specialty consultants available. Educational and recreational facilities abundant in area. Opportunity for immediate substantial income, early corporation membership and eventual purchase of practice to qualified individual. Contact Dept 510 in care of the Journal. 10-12/82

Kurten Medical Group is expanding, and offers excellent opportunities in orthopedic surgery, oncology, pulmonary medicine, gastroenterology, and OB/GYN. We have an innovative group structure which allows maximum flexibility and the security of a strong group environment. We presently have 23 physicians. Please contact Stephen L Wagner, Administrator, Kurten Medical Group, 2405 Northwestern Ave, Racine, Wis 53404; ph 414/632-7521. 11tfn/82

Board eligible/Certified family practitioners needed at multiple locations in northeastern rural Wisconsin. Financial assistance available and negotiable. Excellent locations, communities, recreation areas. Contact J Schmacher, Administrator, Calumet Memorial Hospital, Chilton, Wis 53014; ph 414/849-2386. 12/82;1-2/83

General Surgeon. Small, active JCAH hospital in rural Wisconsin close to Minneapolis/St Paul is seeking a resident, full-time surgeon. Must be Board certified or eligible. All major specialists available for consultation. Write or call CEO, Apple River Valley Memorial Hospital, 221 Scholl St, Amery, Wis 54001; ph 715/268-7151. 12/82

Wanted. An internist interested in cardiology, an orthopedist and a psychiatrist. Work part-time (20-35 hours/week) at the Bureau of Social Security Disability Insurance, 310 Price Place, Madison, Wisconsin 53705. If interested, please write or telephone George H Handy, MD, PO Box 7623, Madison, Wis 53707; ph 608/266-1989. 11-12/82

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Family Practitioner needed for primary care, ten physician, multispecialty clinic in northeast Wisconsin. Excellent, well equipped hospitals with 900 beds. Competitive salary and benefits. Contact: F T Mansell, MD, 1751 Deckner Ave, Green Bay Wis 54302; ph 414/468-5621. 11tfn/82

Orthopedic Surgeon wanted to join multispecialty group consisting of 58 physicians located in west central Wisconsin, a city of 50,000 with a state University of 12,000—90 miles east of the Twin Cities. Excellent opportunity for a stimulating practice in a pleasant environment. If interested contact Donald R Griffith, MD, Medical Director, Midelfort Clinic, Ltd, 733 West Claire-mont Ave, Eau Claire, Wis 54702; or call 715/839-5222. 11-12/82;1/83

Family Practice opportunity available to join a long-established, four-physician family practice group in south central Wisconsin. Salary basis initially, leading to full corporate membership. Numerous fringe benefits. Pleasant community. Contact: Chad Burchardt, Business Manager, Medical Associates of Beaver Dam, SC, 1200 N Center St, Beaver Dam, Wis 53916; ph 414/887-7101. 10-12/82

Okauchee, Wis. Thirty miles west of Milwaukee. An attractive lake community needs professional services. Our growing population supports one public and two private grade schools. Our community presents an excellent opportunity for a physician to build a rewarding practice. If you are interested, write to: Okauchee Area Business Association, PO Box 35, Okauchee, Wis 53069. 10-12/82

MARSHFIELD CLINIC, a major multispecialty referral center, is seeking family practitioners for outpatient satellites. Rural location in beautiful central Wisconsin. Excellent salary and fringe benefits. Must be Board certified/eligible. Send curriculum vitae to Frederic P Wesbrook, MD, 1000 N Oak Ave, Marshfield, Wis 54449. 11-12/82

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University of Wisconsin Department of Family Medicine
777 South Mills Street, Madison, Wisconsin 53715
Phone: 608/263-4095
1-12/82

Physicians Exchange

continued

Doctors needed—in Wisconsin. All specialties and all locations. For confidential information, mail your CV to: Medicus, 1525 Wisconsin Ave, Grafton, WI 53024. 6tfn/82

Wausau Medical Center, SC, a 50-physician multispecialty group has openings for physicians in the following specialties: *OB/GYN, Otolaryngology, Cardiology, Neuroradiology,* and *General Surgery.* Competitive first-year salary, incentive plan thereafter. Comprehensive fringe benefits. New facility near new hospital. Located in beautiful, quiet, central Wisconsin, metropolitan area of 65,000. Recreational opportunities abundant. For more information contact: K L Day, MD, Wausau Medical Center, SC, 2727 Plaza Drive, Wausau, Wis 54401, or call collect 715/847-3351. 6tfn/82

Family Physician to join three Board certified family physicians in a young and growing medical practice in Central Minnesota. The practice is orientated toward Family Practice Medicine and located centrally in the state with quick access to the Minneapolis-St Paul area. Both practices are a short distance from the St Cloud area, and our physicians use the St Cloud Hospital for hospitalization of their patients. Cultural and recreational activities are abundant in this area of Minnesota. The salary and fringe benefits are open and negotiable. If interested, please contact Thomas J Newton, MD, Medical Director, or contact Daryl G Mathews, Administrator, at either the St Joseph or Cold Spring Medical Clinics, 26 North Red River Ave, Cold Spring, Minnesota 56320; or call collect (612) 685-8641 or (612) 363-7765 in St Joseph, Minnesota. 7-10/82

Family Physician wanted to teach and practice. University of Missouri-Kansas City Department of Family Practice. Residency Program has 18 residents, has four other full-time and four part-time faculty. Suburban location. New clinic. Certification by American or Canadian Board required. Salary competitive depending upon experience. Contact Family Practice Department, University of Missouri-Kansas City School of Medicine, Truman Medical Center/East, Route 17, Kansas City, MO 64139; ph 816/373-8210. Attention: Thomas A Nicholas, MD. 12/82;1/83

U S Air Force Medical Corps currently is accepting applications for physicians in the following specialties: *Surgery (all specialties), Obstetrics/Gynecology, Otorhinolaryngology, Anesthesiology, Urology, Rheumatology, Neurology, Psychiatry.* For further information call collect, MSGT Charles Brown Jr, 414/258-2480. 11-12/82

Surgeon with general vascular training, Ophthalmologist, and ENT, to join a progressive multispecialty group of 17 physicians consisting of General/Family Medicine, General Surgery, Internal Medicine, OB-GYN, Ophthalmology, Orthopaedic Surgeon, Pediatrics/Adolescent Medicine, and Radiology. Subspecialties include: Pathology, Vascular Surgery, Cardiovascular Diseases, Gastroenterology and Endoscopy. We are located in a fast growing, scenic, lake country area between Milwaukee and Madison and can offer excellent hospital, schools, and recreational facilities. Full fringe benefit package. Contact: James F Dowd, Admin, Wilkinson Clinic SC, 915 East Summit Ave, Oconomowoc, Wis 53066; ph 414/567-4433. 10tfn/82

Family Practitioner needed to join multispecialty group of 33 physicians dedicated to primary care in East Central Wisconsin community. City population 38,000, drawing area 100,000. Attractive income arrangements, association membership possible after one year, pension and profit sharing, extensive fringe benefits. Contact R B Windsor, MD, 1011 North 8th St, Sheboygan Wis 53081; ph 414/457-4461. 10tfn/82

Ideal practice opportunities for Family Practice and Internal Medicine in scenic Kettle Moraine area, Plymouth, Wisconsin. Less than one hour drive from Milwaukee, 60 miles from Green Bay. Service community of 20,000. Modern JCAH hospital and 60-bed nursing home. Family-oriented community with good industrial base. Please contact: Peter R Strub, Coordinator, Physician Recruitment Committee, Plymouth Hospital, Inc, 901 Reed St, Plymouth, Wis 53703; ph 414/893-1771. 8tfn/82

Internal Medicine Board certified or Eligible primary care internist to practice with nine man multispecialty group consisting of five general internists; two pediatricians; one Ob/Gyn; and one general surgeon. Primary location of practice in rural community branch clinic. Back up and coverage from main group. Community is on a lake with recreation and sports available. Main clinic is 45 miles northwest of Milwaukee. Join a progressive medical group. Contact J L Algiers, MD or Clinic Manager at Parkview Medical Associates, Ltd, 1004 E Sumner St, Hartford, Wis 53027; or call collect 414/673-5745. Milwaukee metro telephone is 414/344-2982. 12tfn/82

Primary Care—Union Grove Opportunity. Physician with background in general practice, pediatrics or internal medicine sought for full-time position with Department of Health and Social Services at Southern Wisconsin Center. This State facility, 20 miles south of Milwaukee, is engaged in the care of the developmentally disabled. Contact John F Brown, MD, Medical Director; c/o Southern Wisconsin Center, 21425 Spring St, Union Grove, Wis 53182; ph 414/878-2411, ext 362. 12/82

We are a progressive two-man practice looking for a third residency trained family practitioner. Located in northwestern Wisconsin, the distance to Minneapolis is 120 miles, and to Duluth 80 miles. The salary is to include guaranteed base plus incentive as well as other benefits. For further information, please call or write 1-715/635-8795, Family Practice Clinic of Spooner, Spooner Medical Center, PO Box 40, Spooner, Wis 54801. 12/82

Family Practice, Oconto, Wis. Thirty miles north of Green Bay. Rural community of 4,600 people needs a 4th family physician. New clinic. Forty bed hospital. Excellent hunting, fishing, and other recreational activities. Please contact Glen Heinzl, MD, 1007 Pecor St, Oconto, Wis 54153 or call collect 414/834-2201. p12/82; 1-3/83

Family Physician for Locum Tenens. Experienced Board certified family physician for 9 years on the full time faculty of the University of Wisconsin Medical School, available for Locum Tenens, all areas of Wisconsin. Contact: Rudolph C Hecht, MD, 312 Newcastle Way, Madison, Wis 53704; ph (home) 608/249-5201. 10-12/82

Family Practitioner—Immediate need to associate with busy, Board certified family practitioner in Tomah. Modern clinic, 57-bed local hospital, and formal association with 52-physician multispecialty clinic in La Crosse. Tomah is an active, growing community of 7,000 with a medical service area of 20,000. Contact: P S Shultz, MD, Medical Director, Skemp-Grandview-La Crosse Clinic, 815 S 10th St, La Crosse, Wis 54601; ph 608/782-9760. 11-12/82

Grow with us in the Sunbelt. The INA Healthplan needs physicians in family practice and most specialties in Miami, Tampa, Dallas, Houston, Phoenix, Tucson, and Los Angeles. Attractive salaries and comprehensive benefits including professional development, retirement and profit sharing programs are provided. If team interaction and casual living interest you, send a brief CV to medical Administration, INA Healthplan, Inc, 7616 LBJ Freeway, Suite 303, Dallas, Tex 75251.
p12/82; 1-2/83

La Crosse—Dynamic, 52-physician, multispecialty clinic is recruiting in the following specialties: *General/Vascular Surgery, Neurology, Family Practice, Neonatology, Ophthalmology.* Strong in primary and secondary care, we have six active satellite clinics. Modern 350-bed hospital with CT scanner and medical staff of 92 MDs, including neurosurgeon, immediately adjacent to clinic building. La Crosse is a progressive, family-oriented city of 50,000 in the beautiful Mississippi River Valley with a medical referral area of greater than 200,000. Exceptional cultural, educational, and recreational opportunities locally. Contact: P S Shultz, MD, Medical Director, Skemp-Grandview-La Crosse Clinic, 815 S 10th St, La Crosse, Wis 54601; ph 608/782-9760. 11-12/82

Neurologist wanted—to join a very busy, well established neurosurgeon in North Central Wisconsin. Active practice assured, extremely good income potential. New modern office located in a new hospital. Excellent community approximately 65,000 population with unlimited outdoor recreation and very good school systems. For more information contact Lloyd Engstrom. Call collect 715/842-3202 or write PO Box 1646, Wausau, Wis 54401. 12/82; 1-2/83

Family Practice Physician to share fully equipped medical office in central Wisconsin city. Opportunity for partnership and eventual purchase of practice. Excellent recreational, educational, hospital, and civic advantages. Send curriculum vitae to Dept 503 in care of the Journal. 6tfn/82

Family Physician to join our group of six Board certified family practitioners and Board certified general surgeon. Liberal vacation and educational allowances. Competitive salary first year with incentive bonus, and full membership after one year. Blue Earth is a farming town of 4000 in Southern Minnesota with a drawing area of 25,000. 35-bed hospital with adjoining clinic facilities. Complete opportunity for an aggressive young family physician. Please contact Marjeane Werner or Thomas E Watts, MD, Blue Earth Medical Center, Ltd, 520 South Galbraith, Blue Earth, Minn 56013; ph 507/526-7371.
8-12/82; 1/83

Adult Psychiatrist to join well established group in a community of 50,000 with large referral area. Two excellent hospitals, University, and industrial area. Salary—open. Excellent benefits. For further information contact: J M Tobin, MD, Northwest Psychiatric Clinic, Eau Claire, Wis 54702; ph 715/834-2751. 8-12/82; 1/83

The Racine Medical Clinic, a progressive cluster corporation of 25 physicians, is currently seeking an orthopedic surgeon and an invasive cardiologist. Full benefits, unlimited earnings and a full and exciting practice are offered. Please contact: Roger D Lacock, Administrator, Racine Medical Clinic, 5625 Washington Ave, Racine, WI 53406; ph 414/886-5000. 1tfn/82

Locum tenens services. Wisconsin-licensed family physician available and also needed. Our physicians do office, hospital, emergency room and OB work. Call or write: INTERHEALTH, 5695 Merry Lane, Excelsior, MN 55331; ph 612/474-4372. 10-12/82;1-4/83

Board certified Obstetrician and Gynecologist is seeking a position in Southern Wisconsin. Contact Dept 512 in care of the Journal. 12/82

Family Physician or Internist to join three-man family and general practice group in the heart of North Central Wisconsin vacationland. First year guaranteed salary. Numerous fringe benefits. Clinic across from hospital. Send CV to: O M Francisco, MD, 221 E Washington Ave, Tomahawk, Wis 54487; ph 715/453-2147. 5tfn/82

Miscellaneous

Physicians Signature Loans to $50,000. Up to 7 years to repay. Competitive fixed rate, with no points, fees, or charges of any kind. No prepayment penalties. Prompt, courteous service. Physicians Service Assn, Atlanta, GA. Toll-Free (800) 241-6905. 11tfn/82

Experienced middle-aged family nurse practitioner seeks practice opportunity in Milwaukee or surrounding area. Desire general primary care with adults and children plus opportunity for health education, weight reduction, and stress management programs for individuals and groups. Open to part-time until practice builds. For vitae/interview, contact J D Wida, MSN, 414/962-3958. 11-12/82

Reception Area Aquariums. Beautify your reception area or office with a relaxing decorator aquarium—many styles to choose from—designed even for small areas. Complete maintenance service available. Lease or purchase option. Contact: Creative Pet Designs, PO Box 26172, Milwaukee, Wis 53226; ph 414/778-1999. p12/82; 1tfn/83

Medical Facilities

Medical office space for lease. New Swiss chalet style building in fast growing community. Needs family practitioner, pediatrician, etc. Building has dentist and pharmacy. Very reasonably priced in Waukesha County near expressway. Info: call 414/781-1155. 7tfn/82

Two-story medical office building for sale, New London, Wis, for single or group practice. Fully equipped and ready for occupancy Nov 1, 1982. Reason for vacancy—physician retiring from very active 50-year practice. First floor includes four examining rooms, lab and x-ray facilities, large waiting room, and bookkeeping office. Call 414/982-2144 Monday through Thursday; 414/982-3615, evenings and weekend. 10-12/82

Office furniture for sale. Metal desk and credenza. One swivel and two contemporary chairs with floor lamp. Call 414/332-4241 after 4:00 pm. g10tfn/82

Established solo practice in internal medicine for sale. Available immediately. Located in Milwaukee area. For information call 414/332-9006 or contact Dept 509 in care of the Journal. g9/82

Office space, professional building entire level. West Allis. Near hospital. Call 414/543-8864. 12tfn/82

Medical Office for lease. Located in Grafton, Wisconsin, 20 miles north of Milwaukee in the Grafton State Bank building on the fifth floor. Ideal for family practice or specialist. Attractive graded rent schedule call for details. Scott Campbell, Darlene Hausmann. Phone 414/377-5511. p12/82

Meetings/CME Courses

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is a nominal charge for listing of Continuing Medical Education courses at the following rates: 50¢ per word, with a minimum charge of $20.00 per listing. BOXED LISTINGS: $32.00 per column inch. Listings of other scientific meetings will be included at the discretion of the editors. COPY DEADLINE for listings is tenth of the month preceding the month of publication; e.g., copy for the August issue is due by July 10. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 800/362-9080. For listing of other meetings see the Special Issue of the Journal of the American Medical Association: Continuing Education Courses for Physicians for period Sept 1, 1982 through Aug 31, 1983.

WISCONSIN

JANUARY 12-14, 1983: *Clinical Cancer Conference,* The Telemark Lodge, Cable. Sponsored by Marshfield Clinic, Duluth Clinic, Wisconsin Cancer Society and the Minnesota Cancer Society. Info: Office of Medical Education, 1000 North Oak Ave, Marshfield, Wis 54449; ph 715/387-5207.

JANUARY 17-19, 1983: *New Therapeutics III: The Results of Recent Advances in Medicine,* at Telemark Lodge, Cable. Sponsored by University of Wisconsin School of Medicine and University of Wisconsin-Extension, Department of Continuing Medical Education. Approved 14 credit hours of Category I of AMA/AAFP; 1.4 CEUs UW-Extension Continuing Education Units. Fee: $235. Info: Ann Bailey, Administrator, CME, 454 WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2854.

JANUARY 21, 1983: *Reality Orientation*, at Mendota Mental Health Institute, Madison. Presented by Institute Staff. Contact Training Dept, Mendota Mental Health Institute, 301 Troy Drive, Madison, Wis 53704; phone 608/244-2411.

JANUARY 26-28, 1983: *13th Annual Winter Refresher Course for Family Physicians,* The Pfister Hotel and Tower, Milwaukee. Sponsored by Dept of Family Practice Medical College of Wisconsin, and the Southeast Chapter of the Wisconsin Academy of Family Physicians. (Further details elsewhere in this section)

STATE MEDICAL SOCIETY OF WISCONSIN
Dates and Locations of Annual Meetings
1982-1992

All meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) and the new Hyatt Regency as the headquarters hotel with the exception of 1985, when the meeting will be held at the LaCrosse Convention Center.

1983—Mar 24-26	**1988—Apr 28-30**
1984—Mar 29-31	**1989—Apr 13-15**
1985—Apr 25-27	**1990—Apr 26-28**
1986—Apr 17-19	**1991—Apr 18-20**
1987—Mar 26-28	**1992—Apr 23-25**

Meeting days will be Thursday and Friday; the first session of the House of Delegates will convene on Thursday, the second and third on Friday. Scientific programming will be on Friday and Saturday.

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701. Local telephone: 257-6781; toll-free in Wisconsin: 1-800/362-9080.

JANUARY 27-28, 1983: *Basics of Treatment Planning*, at Mendota Mental Health Institute, Madison. Presented by Institute Staff. Contact Training Dept, Mendota Mental Health Institute, 301 Troy Drive, Madison, Wis 53704; phone 608/244-2411.

FEBRUARY 16-18, 1983: *Medical/Surgical Update '83.* The Telemark Lodge, Cable. Sponsored by Marshfield Clinic. Info: Office of Medical Education, 1000 North Oak Ave, Marshfield, Wis 54449; ph 715/387-5207.

FEBRUARY 19, 1983: Wisconsin Dermatological Society, University Hospitals, Madison.

FEBRUARY 23, 1983: *Gastroenterology: A Nursing Perspective,* Pfister Hotel, Milwaukee. Sponsored by the Medical College of Wisconsin. (Further details elsewhere in this section)

FEBRUARY 23-26, 1983: *Gastrointestinal Endoscopy: Update 1983* Pfister Hotel, Milwaukee. (Further details elsewhere in this section)

MARCH 10-11, 1983: *8th Annual Ophthalmology Current Concepts Seminar '83,* at Concourse Hotel, Madison. Sponsored by University of Wisconsin School of Medicine, Department of Ophthalmology; and University of Wisconsin-Extension, Department of Continuing Medical Education. AMA Category I, University of Wisconsin Continuing Education Units. Info: Sarah Z Aslakson, CME, 465 B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

APRIL 14-16, 1983: *Advances in Infectious Disease*, Madison. Sponsored by University of Wisconsin, School of Medicine, Dept of Medicine; University of Wisconsin-Extension, Continuing Medical Education. Approved AMA Category I, University

13th ANNUAL WINTER REFRESHER COURSE FOR FAMILY PHYSICIANS

January 26-28, 1983/The Pfister Hotel and Tower Milwaukee, Wisconsin

The Department of Family Practice, Medical College of Wisconsin and Southeast Chapter of the Wisconsin Academy of Family Physicians.

This three day program features lectures and workshops for family physicians in active practice providing current information on some of the major disciplines of medicine. In addition, a special hands-on workshop on suturing techniques will be presented.

Fee: $200

Info: Mrs Susanna Rechlitz, Conference Manager, Department of Family Practice, 2200 West Kilbourn, Milwaukee, Wisconsin 53233. Phone: 414/931-1030.

12/82

of Wisconsin-Extension Continuing Education Units, AOA, Family Practice credits. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

APRIL 29-30, 1983: *Selection and Interpretation of Laboratory Tests for the Clinician,* University of Wisconsin, Madison, Clinical Science Center. Sponsored by University of Wisconsin-Extension, Continuing Medical Education; University of Wisconsin School of Medicine, Department of Medicine. AMA Category 1, University of Wisconsin-Extension, Continuing Education Units; AAFP, AOA. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, WI 53706; ph 608/263-2856.

APRIL 28-29, 1983: *9th National Conference on Case Resolution of Complex Industrial Injured,* Paper Valley Hotel, Appleton. Sponsored by Industrial Injury Clinic, Neenah, WI; Theda Clark Regional Medical Center, Neenah, WI; University of Wisconsin-Extension, Continuing Medical Education. University of Wisconsin-Extension CEU's, AMA Category 1, Continuing Legal Education Credit, Rehabilitation Counselor Certification. Info: Sarah A Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, WI 53706; ph 608/263-2856.

MAY 4-6, 1983: *6th Annual Symposium on Cardiac Rehabilitation: Update 1983,* Red Carpet Hotel, Milwaukee. Sponsored by Mount Sinai Medical Center (Cardiovascular Disease Section), Milwaukee and the University of Wisconsin-Extension, Health Sciences Unit, Dept of Continuing Medical Education in cooperation with the American College of Sports Medicine, and the American Heart Association, Wisconsin Affiliate. AMA Category 1, University of Wisconsin Continuing Education Units. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, WI 53706; ph 608/263-2856.

MAY 13-14, 1983: *Back Pain Conference,* Madison. Sponsored by University of Wisconsin-Extension, Dept of Continuing Medical Education and University of Wisconsin, School of Medicine, Dept of Family Medicine and Practice. AMA Category 1; AAFP prescribed credit, AOA Category 2-D, University of Wisconsin-Extension CEU's. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, WI 53706; ph 608/263-2856.

OTHERS

FEBRUARY 18-19, 1983 (Florida): *Fifth Annual Oncology Update,* Cedars Medical Center, Inc, 1400 Northwest 12th Ave, Miami, FL 33136. Programs will include such topics as "Hepatic Perfusion Results with Implanted Infusaid Pump," and "New Developments in Chronic Lymphocytic Leukemia and Its Variants." Approved 11.5 credit hours in Category 1 of AMA-PRA. Fee: $165. Info: Ms Thelma MacGregor at 305/325-5558. 12/82;1/83

FEBRUARY 27-MARCH 3, 1983 (New Mexico): *Eighth Annual New Mexico Metabolism Symposium,* at Tennis Ranch of Taos, Taos, New Mexico. Program designed to provide both practical and theraretic insight regarding diet, exercise, and insulin in diabetic management for interested physicians. Fee: $145. Approved 15 credit hours of Category 1 of AMA-PRA. Info: Office of Medical Education, Lovelace Medical Center, 5400 Gibson Blvd, SE, Albuquerque, NM 87108; ph 505/842-7353. p12/82; 1/83

MARCH 7-8, 1983 (Michigan): *Seventh Annual Winter Pediatric Seminar,* at Caribou Lodge, Powderhorn Ski Area, Bessemer, Mich. Registration fee: $65.00, includes amenities; deadline March 1; enrollment limited to first 75 registrants. Credit: Approval for 6 hours credit from Wisconsin Academy of Family Physicians has been granted. Program also approved for 8 hours CME Category 1 credit by AMA-PRA. Registrants responsible for own housing accommodations. Further info: Office of Medical Education, Marshfield Clinic, 1000 North Oak Ave, Marshfield, Wis 54449; or telephone 715/387-5207. p12/82

EASTER WEEK CME CRUISE/CONFERENCE ON MEDICOLEGAL ISSUES. April 2-9, 1983, Mexican Riviera. 18 CME Category 1 credits. Fly roundtrip free to Los Angeles. Excellent group fares on finest ship. Registration limited. Tax deductible under 1976 Tax Reform Act. Information: International Conferences, 189 Lodge Ave, Huntington Station, NY 11746; ph 516/549-0869. p12/82

NEW POLICY

The Editorial Board has established a new policy for the listing of meetings and continuing education programs. Listings of continuing medical education programs, having a registration fee, will be accepted for publication at the following rates: 50¢ per word, with a minimum charge of $20.00 per listing; boxed listing $32.00 per column inch, with free listing in the unboxed columns. Other listings of meetings, without a registration fee, will be accepted without charge at the discretion of the editors. The above policy applies to listings in Wisconsin as well as in other states and countries.

Medical College of Wisconsin 9th Annual Postgraduate Endoscopy Conference

GASTROINTESTINAL ENDOSCOPY: UPDATE 1983

February 23-26, 1983/Pfister Hotel Milwaukee, Wisconsin

The three-day conference which features a faculty of endoscopic experts and educators will emphasize formal lectures, case presentations, mini-group demonstrations of endoscopic techniques, panel discussions, self-assessment testing and faculty reviews, exhibits and instructional endoscopic movies.

CO-DIRECTORS: Walter J Hogan, MD/Joseph E Geenen, MD

Fee: $350

Info: Gastroenterology Section, PO Box 1608, Milwaukee, Wisconsin 53201-1608; ph 414/931-1030. 12/82

Sixth Annual GI Assistants Course

GASTROENTEROLOGY: A NURSING PERSPECTIVE

February 23, 1983/Pfister Hotel Milwaukee, Wisconsin

Course Director: James P Brook, RN

It is the objective of this Postgraduate Course to bring into practice perspective an updated, critical overview of today's requirements and expectations for the "well-trained" GI nurse assistant which will be presented by an outstanding faculty of endoscopists, endoscopy nurses and representatives of instrument and pharmaceutical companies.

This course is being held in conjunction with the 9th Annual Postgraduate Endoscopy Conference, sponsored by the Medical College of Wisconsin, February 23-26, 1983.

Fee: $125.

Info: Gastroenterology Section, PO Box 1608, Milwaukee, Wisconsin 53201-1608; ph 414/931-1030. 12/82

AMA

JUNE 19-23, 1983: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 4-7, 1983: Interim AMA House of Delegates, Los Angeles, CA.

JUNE 17-21, 1984: Annual AMA House of Delegates, Chicago, IL.

DECEMBER 5-7, 1984: Interim AMA House of Delegates, Honolulu, Hawaii. ■

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Bookshelf

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School and by others who are particularly qualified. Most books here listed will be available on loan from the Medical Library Service, 1305 Linden Drive, Madison, Wisconsin 53706; tel. 608/262-6594.

Executive Fitness, prepared by Executive Health Examiners (EHE). Series editor, Richard E Winter, MD. McGraw-Hill Book Company, 1221 Avenue of the Americas, New York, NY 10020. 1982. Pp 210. Price: $14.95.

Coping with Executive Stress, prepared by Executive Health Examiners (EHE). Series editor, Richard E Winter, MD. McGraw-Hill Book Company, 1221 Avenue of the Americas, New York, NY 10020. 1982. Pp 210. Price: $14.95.

Executive Nutrition and Diet, prepared by Executive Health Examiners (EHE). Series editor, Richard E Winter, MD. McGraw-Hill Book Company, 1221 Avenue of the Americas, New York, NY 10020. 1982. Pp 210. Price: $14.95.

Stand Tall! The Informed Woman's Guide to Preventing Osteoporosis. By Morris Notelovitz, MD and Marsha Ware. Triad Publishing Company, Inc, PO Box 13096, Gainesville, FL 32604. 1982. Pp 208. Price: $12.95.

The Blue Book For the Apple® Computer. 2nd Edition. The Apple Directories, WIDL VIDEO, Chicago, 5245 W Diversey Ave, Chicago, IL 60639. 1982. Price: $24.95.

The Home Hospital: How the Family Can Cope with Catastrophic Illness. By Lois Barclay Murphy. Basic Books, Inc, Publishers, 10 East 53rd St, New York, NY 10022. 1982. Pp 348. Price: $15.50. ■

PRACTICE MANAGEMENT COURSES

Marketing strategies for private practice. A new workshop for physicians offered by AMA at its headquarters in Chicago, November 5, December 10, 1982 and January 28, 1983. Session includes an update on major health care trends, improving referral patterns, enhancing patient satisfaction, and development of a coordinated marketing plan for solo physicians and small groups. Fees are $150 for members and $185 for nonmembers. Sessions limited to 30 registrants. Contact Dept of Practice Management, AMA Headquarters, 535 North Dearborn St, Chicago, Ill 60610; phone 312/751-6000; for brochure describing course. g10-12/82

PLACEMENT SERVICES

Opportunity Placement Register and **Physician Placement Register.** August/September issues now available from the AMA. The OPR contains hundreds of medical practice openings throughout the US. The PPR lists physicians seeking practice locations. Also available is a brochure, *Preparing a Professional Vitae*, designed to aid physicians in resume writing. To get a complimentary copy of any of these publications, write Physicians' Placement Service, AMA Headquarters, 535 North Dearborn St, Chicago, Ill 60610, or phone 312/751-6282. g10tfn/82

ANNOUNCEMENTS

NEW POLICY

The Editorial Board has established a policy for publication of announcements which involve referral of patients for designated studies or surveys, specialized healthcare services offered, practice management programs, and the like. These announcements will be accepted, at the discretion of the editors, at the following rate: $3.00 per line (average nine words per line).

MEMBERSHIP FACTS

ARE YOU A MEMBER of the State Medical Society of Wisconsin, or do you know someone who isn't? Whether you're just starting medical school, maintain a full-time practice, or are retired, SMS has a membership classification to fit your individual needs. Election to membership by the County Medical Society in which your principal place of practice is located carries with it membership in the State Medical Society of Wisconsin and, if you wish, the American Medical Association. If you qualify for resident membership at the time of your election, your membership dues are greatly reduced. This may also qualify you for reduced dues the first two years of your practice. Dues for regular membership in 1983 are $430 for SMS, $315 for AMA, and county society dues vary. A more detailed listing of SMS membership classifications and their corresponding dues follows:

State Medical Society of Wisconsin

DESCRIPTION OF MEMBERSHIP CLASSIFICATIONS

Regular: Member in active practice. Some are regular members that have reduced SMS and/or AMA dues because they are new practitioners (first year or two out of residency).

Resident: Physician who at January 1 of dues year is in an approved training program as a hospital resident or research fellow who is licensed to practice medicine and surgery in Wisconsin.

Military Service: Members who are serving in the U.S. armed forces (generally not to exceed five years).

Associate: Member whose dues are waived because of illness or financial hardship. This classification is temporary and is reviewed on an annual basis.

Life: Member who has held membership in a state medical society for 50 years or is a Past President of the State Medical Society of Wisconsin.

Honorary: Member who was named by the Board of Directors in recognition of long and distinguished service to the cause of medicine.

Retired: Member who has completely retired from practice (works less than 240 hours per year). All dues are waived unless county society indicates they wish to charge county dues.

Part-time Practice: Physician, regardless of age, who practices 1,000 hours or less during the calendar year but does not qualify for retired membership.

Over Age 70: Member in active practice who is over 70 years of age as of January 1.

Candidate: Member attending a medical school in Wisconsin or fulfilling a postgraduate obligation prior to eligibility for licensure.

Scientific Fellow: Member who is engaged in teaching one or more of the basic sciences at an accredited college or university, and not holding the degree of Doctor of Medicine or Osteopathy.

Emeritus: Retired members who have chosen not to renew their license.

1983 DUES AMOUNTS FOR THESE CLASSIFICATIONS

	SMS	AMA	COUNTY
Regular	$430	$315	Normal County Dues
Resident	43	45	Varies
Military Service	-0-	315 or 45	-0-
Associate	-0-	-0-	-0-
Life	-0-	-0-*	-0-
Honorary	-0-	-0-*	-0-
Retired	-0-	-0-*	-0-
Part-time Practice	215	315*	Normal County Dues
Over Age 70	215	-0-*	Normal County Dues
Scientific Fellow	-0-	-0-	
Emeritus	-0-	-0-*	
Candidate—			
Freshman Year Medical Student	-0-	15	Varies
Sophomore and Succeeding Medical Student Years	10	15	Varies
Postgraduate—One	10	45	Varies

*Due to recent policy changes by the AMA, future exemptions from AMA dues will be given to those physicians who are over 70 years of age *and* are retired from practice or practice 1000 hours or less a year.

State Society dues are prorated on a monthly basis for those elected to membership July 1 through September 30. Those elected after September 30 have no dues payable for the balance of the year in which they are elected. AMA dues follow the same pattern except prorating is on a semiannual basis rather than monthly basis.

1983 MEMBERSHIP DIRECTORY. For the past two years the Membership Directory has been published in the January issue. In 1983 it will be published in the July issue, thus making it as current as possible since delinquent members are removed from the roster on May 15 in accordance with the Constitution and Bylaws of the State Medical Society. Therefore, the May 31 monthly computerized membership roster will be used in development of the Directory. Further information on the Directory issue will be provided in subsequent issues of the WMJ.

News You Can Use

By EARL THAYER, Secretary/BERNIE MARONEY, Assistant Secretary

COURT UPHOLDS WORKERS' RIGHT TO ACCESS TO HEALTH RECORDS. A 1980 US Labor Department rule requiring employers to give workers access to certain health and safety records was upheld last month by a Federal district court in Louisiana. The decision was the first judicial test of the rule.

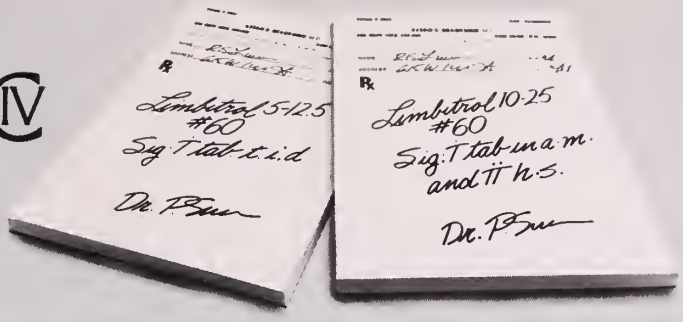
The Louisiana Chemical Association had charged the Labor Department's Occupational Health and Safety Administration (OSHA) did not have the authority to issue such a rule. The court said that "given the insidious nature and long-term effects of many latent occupational diseases, a rule which establishes a data base for medical research, as does the records access rule, falls within the authority of the job-safety agency." The rule allows employees, their representatives and OSHA to inspect records kept voluntarily by companies on worker exposure to dangerous substances and on job-related medical examinations, complaints and treatment. The court also stated that the rule doesn't require employers to keep the records, but deals with access to records already being kept. Meanwhile, OSHA is proposing to narrow the scope of the rule by limiting the number of workers who could be covered and reducing the time such records must be retained.

IMPORTANT NOTICE TO HOSPITAL-BASED PHYSICIANS. On September 3, 1982 President Reagan signed into law the Tax Equity and Fiscal Responsibility Act (TEFRA) which changes the way that certain physicians' services under Medicare are to be reimbursed when provided in a hospital. On October 1, 1982 the Federal Dept of Health and Human Services (HHS) issued proposed rules for implementing part of this new law. SMS and the AMA find the proposed regulations highly objectionable in major areas and will submit detailed comments in opposition to the HHS proposal. SMS has heard that some hospitals may be taking immediate steps to make revisions in their contracts with physicians that receive compensation from the hospital and renegotiate these contracts because of the provisions of Section 108 of TEFRA. ***The Tax Act does not require any change in physician contracts with hospitals.*** The HHS regulation, not yet final, would require a time allocation agreement between a hospital and a physician if the hospital wanted to receive reimbursement under Part A (reasonable cost) for physicians' services. In the absence of such an agreement, all services would be considered under Part B. However, HHS has made a proposal which would limit reimbursement for physicians' services under Part B to only those services that require performance by a physician and are not frequently and consistently furnished by nonphysicians. This provision is not required by the law and is highly objectionable and SMS and the AMA are opposed to it. The impact of the TEFRA provisions will vary among hospitals, based on the ratio of Medicare patients to total patients in the hospital. ***TEFRA does not require changes in the way hospitals will be compensated for, or pay physicians for, services to nonMedicare patients. TEFRA does not necessarily require changes in physicians' agreements.*** Furthermore, the proposed HHS rules are not final and may be modified significantly. If physicians do modify agreements with hospitals based on these proposed regulations, provisions should be made to change the agreement if the final rules for Medicare reimbursement change significantly from the proposed rules.

OCCUPATIONAL HAZARDS INFORMATION LAW TO TAKE EFFECT. A new law goes into effect December 1, 1982 which requires all public and private employers in Wisconsin to inform workers about toxic substances, infectious agents, and pesticides in the work place. According to the State Department of Industry, Labor and Human Relations (DILHR), the law's greatest impact will be on government employers, since private employers already have to satisfy federal Occupational Safety and Health Administration (OSHA) standards regarding employee exposure and medical records for toxic substances and harmful agents. The new state law does require employers to provide more information to workers than under OSHA. The "Employees' Right to Know" law places three major responsibilities on employers. Employers will have to: (1) post notices in the work place informing employees of their right to request information about toxic substances, infectious agents, and pesticides; (2) respond to written requests from employees by providing the required information about such substances; and (3) provide education and training for employees who are routinely exposed to toxic substances, infectious agents, or pesticides. More information concerning the new law is available by contacting the Bureau of Safety Inspection of DILHR at 608/266-7731 or by writing to DILHR, "Employees' Right to Know" Law, PO Box 7969, Madison, WI 53707. ■

Limbitrol® IV

Tablets 5-12.5 each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)
Tablets 10-25 each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt)



In anxious depression,

SPECIFIC FOR THE NONPSYCHOTIC PATIENT

Fits the picture of anxiety/depression correlation

Most patients with a mood disorder have a mixture of anxiety and depression. One clinician[1] found a correlation of 0.7 in anxiety and depression scores; another[2] has estimated that 7 of 10 nonpsychotic depressed patients are also anxious. For the dual symptomatology of anxious depression, Limbitrol provides dual medication.

More appropriate for the nonpsychotic depressed and anxious patient

Limbitrol contains both amitriptyline, specific for symptoms of depression, and a benzodiazepine, specific for the symptoms of anxiety. Thus it is a better choice than other dual agents for anxious depression that contain a phenothiazine, a class of antipsychotic drugs less specific for anxiety and now generally avoided in nonpsychotic patients.[2,3]

Avoids the risk of tardive dyskinesia carried by the phenothiazine combinations

The causal relationship between the phenothiazines and other extrapyramidal side effects, including tardive dyskinesia, is well established. In contrast, the reported incidence of these adverse reactions with Limbitrol or either of its components is rare.

References: 1. Claghorn J: *Psychosomatics 11*:438-441, Sept-Oct 1970. **2.** Rickels K: Drug treatment of anxiety, in *Psychopharmocology in the Practice of Medicine,* edited by Jarvik ME. New York, Appleton-Century-Crofts, 1977, p. 316. **3.** Boldessarini RJ, Torsy D: Tardive dyskinesia, in *Psychopharmocology: A Generation of Progress,* edited by Lipton MA, DiMoscio A, Killam KF. New York, Raven Press, 1978, p. 999.

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Relief of moderate to severe depression associated with moderate to severe anxiety
Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use; then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.
Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide)
Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.
Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.
The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs.
Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.
Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.
Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.
Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.
Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.
Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.
Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.
Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels.
Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.
Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.
Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly. Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased to six tablets or decreased to two tablets daily as required. Limbitrol 5-12.5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses.
How Supplied: White, film-coated tablets, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 50.

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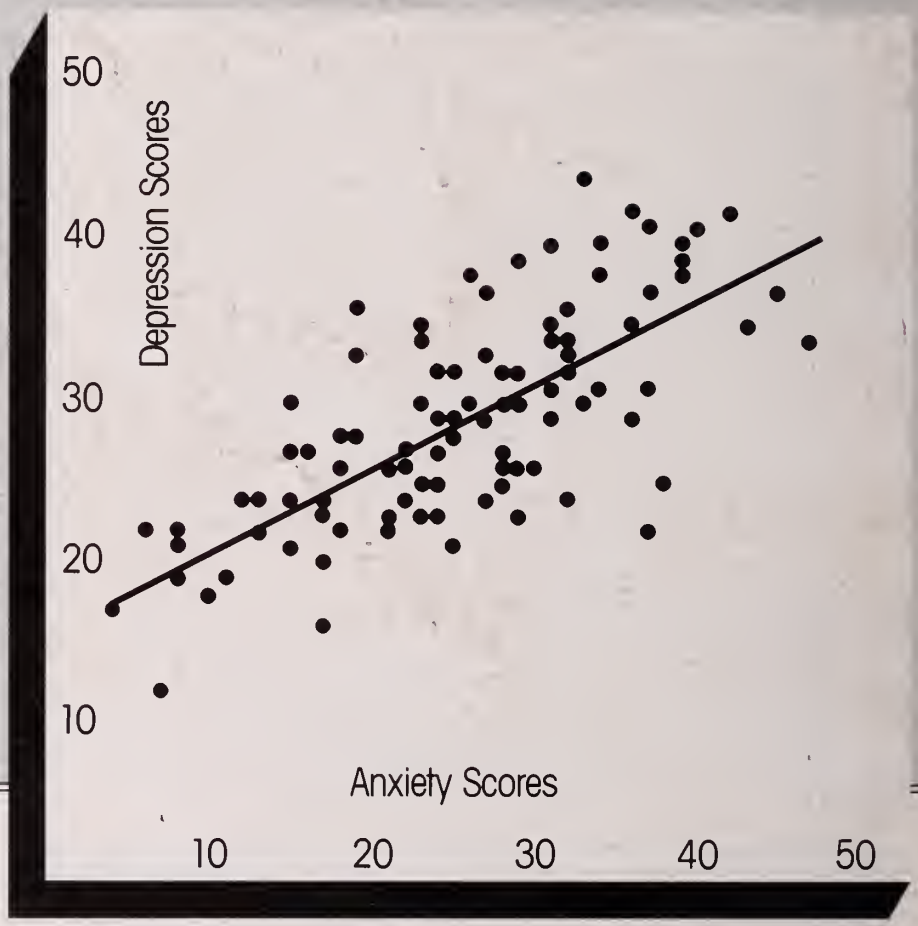
MORE DEPRESSION MEANS MORE ANXIETY...



The graph illustrates the close correlation between depression and anxiety derived through the MMPI and the Taylor Manifest Anxiety Scale in 100 nonpsychotic psychiatric patients. The Coefficient of Correlation is 0.7. As depression increased, so did the anxiety levels.
—Adopted from Claghorn J[1]

A key reason why

MORE PHYSICIANS ARE CHOOSING LIMBITROL®

Tablets 5-12.5 each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)
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1. Claghorn J: *Psychosomatics 11*:438-441, Sept-Oct 1970

Please see summary of product information on inside cover.

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